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MAR 5 1941

the MODERN HOSPITAL

VOLUME 56 MARCH 1941 NUMBER 3

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For March 1941

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Just in Passing—

APPROXIMATELY 800 hospitals have already replied to a recent nation-wide inquiry on building contemplated during 1941. Of these, 153 report new buildings or additions under way or planned for this year and 252 report remodeling and other major renovation to be undertaken in 1941. Thus, a total of 405, or more than 50 per cent of all those so far reporting, are planning some kind of physical improvement this year. Another 25 per cent plan important additions of equipment during the year.

IT IS interesting to note the changes in sentiment on controversial points among hospital administrators. A few years ago, for example, most hospital administrators considered vacations as a preparation for service to come. Now many believe that vacations can properly be given as a reward for past service. This is but one of the several interesting facts to be presented in the April Small Hospital Forum on vacations and sick leave.

DO YOU have difficulty in getting trustees to attend meetings? If so, don't miss the editor's article next month which gives practical pointers in arousing and sustaining trustee interest.

READ AND PASS ALONG

	See page	Date
Administrator		
Purch. Agent	.....	.....
Supt. of Nurses	.....	.....
Surg. Supervisor	.....	.....
Dietitian	.....	.....
Housekeeper	.....	.....
Pharmacist	.....	.....
Engineer	.....	.....
Laundry Manager	.....	.....
Radiologist	.....	.....
Pathologist	.....	.....
Chief of Staff	.....	.....
.....	.....	.....
.....	.....	.....

Return to .....

The Modern Hospital

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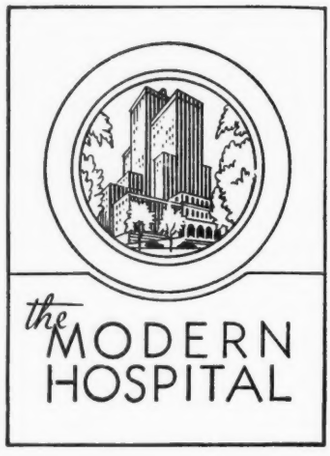

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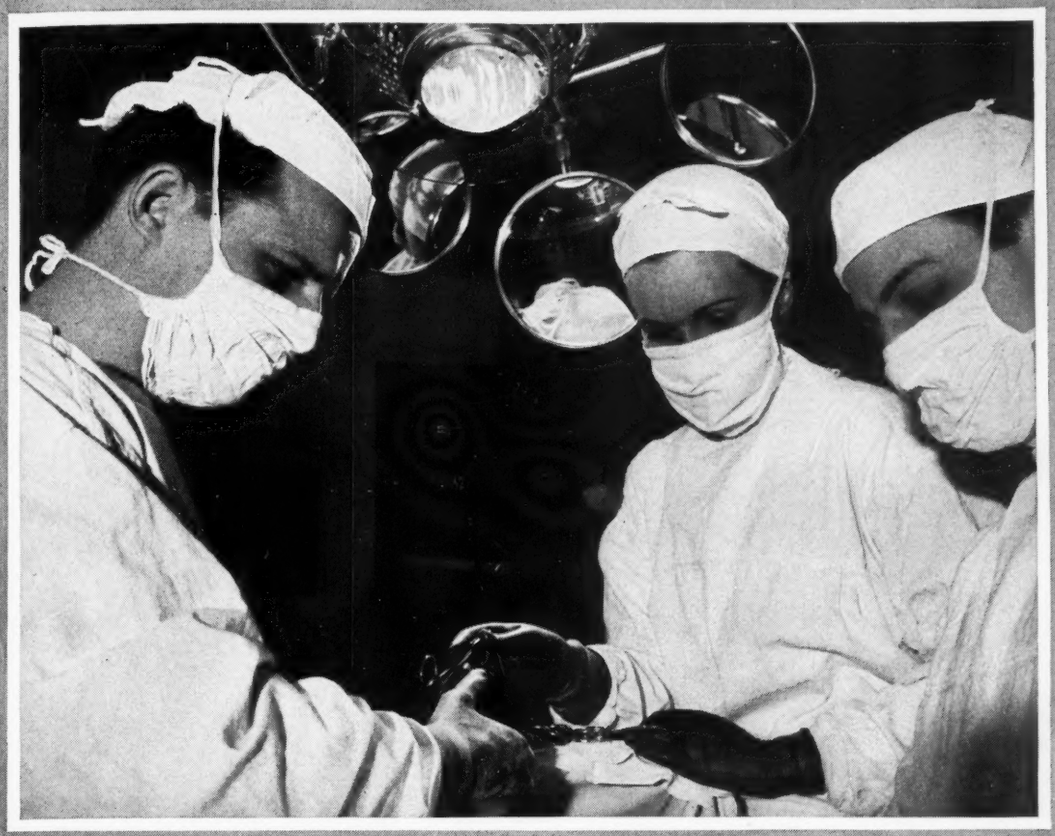

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WITH THE *Roving Reporter*

Prospective fathers wrestle with one of the problems of baby-tending.

School for Fathers

• Add one more to the number of hospitals that, not content merely to educate expectant mothers, are also educating expectant fathers. It is the Methodist Hospital in Brooklyn, N. Y., at which we are stopping for a few minutes to see what is being done to make the husband understand some of the problems that may confront a wife before the baby comes.

"We made the first approach," Mabel Duryea, supervisor of the maternity building, tells us, "through the wife in the mothercraft class, explaining just what we desired to do and why we desired to do it. We asked her to invite her husband for us, thus making the contact absolutely informal and entirely a matter between husband and wife, and removing any possibility of the husband's feeling that the hospital was urging something on him. We were delighted with the results.

"On December 4 at 8 p.m. we ventured out with a series of four classes, the first two of which were lectures, the last two, practical demonstrations. Fourteen attentive and interested expectant fathers were on hand. By their earnest attention and careful questions we knew the answer—such classes were needed.

"One of the attending doctors on the obstetrical staff gave the two lectures. The first was on 'the anatomy and physiology of pregnancy,' the second, 'tips to prospective fathers.' These were presented in terms that the husband could easily understand and were accompanied by interesting slides.

"The last two evenings of the course were practical demonstrations given by the instructor of mothercraft classes. The first was a demonstration bath and the second was on general care of the baby. The instructor gave a demonstration bath to a doll, explaining the various steps in detail and then showing how the baby should be diapered and dressed.

"These demonstrations were staged to teach the husband to be helpful but not to attempt to do more than he knew how to do well. Special emphasis was given to preparing and giving the bottle and the proper procedure following the feeding of the baby. The demonstration of the 'general care of the baby' was a review that afforded each husband who desired it an opportunity to practice on the doll the procedure that had been demonstrated.

"A certificate was presented to the men who completed the course and it was extremely gratifying to see how pleased they were to receive this certificate. They were treated to refreshments consisting of coffee and cakes, too." Already another class is under way, with every indication of increasing registration as prospective fathers become educationally minded.

Fighting the "Flu"

• Hospital visitors, always a problem, become almost a menace when colds, grippe and flu are prevalent. So the Greater New York Hospital Association decided to do something about it. Every member has been urged to discourage visitors to patients during the period when there are so many cases of respiratory infections. This can be accomplished by distributing cards among visitors asking their cooperation and also by placing posters in the lobby of the hospital.

To impress upon the hospitals, and the public, too, the importance of this, a letter from Dr. John L. Rice, commissioner of health, to Leighton Arrowsmith, president of the Greater New York Hospital Association, is being distributed.

"While there is no indication that influenza has reached epidemic proportions here in New York City," the letter points out, "there have been a substantial increase in respiratory infections, such as grippe, colds and sore throats, and an increase in the number of influenza cases reported. It seems to me that people with common colds or other mild respiratory infections are doing their friends who are confined to hospitals for some other ailment no good by visiting them. They may unwittingly be bringing them germs that can cause serious complications."

Happy Easter

• Easter comes late this year to be sure (April 13, to be exact) but it's none too early to start making plans. Your Roving Reporter was reminded the other day of the attractive little card that John Hayes at Lenox Hill Hospital in New York has placed on the breakfast tray of every patient on Easter Sunday. It says: "Good Morning! Happy Easter! We greet you and express our sincere wish that there is within you today the spirit of renewed life and hope which at this Season is so evident all around us." It is signed, "the Entire Personnel of Lenox Hill Hospital." Placed alongside this greeting is half an egg shell, colored, out of which, also glued to the card, comes a small, yellow cotton chicken. The card itself is pale apple green, so the whole effect is cheery and springlike.

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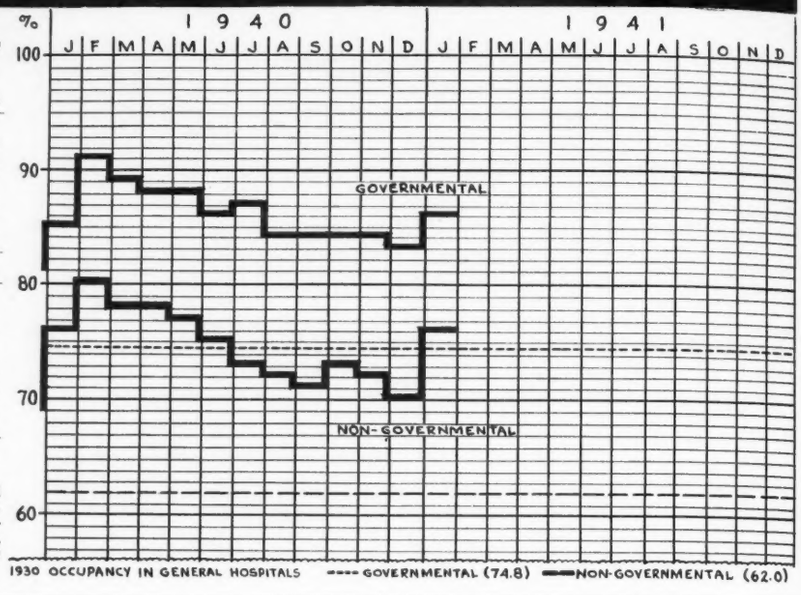
HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data on Reporting Hospitals: Hosp.[1]	Beds[2]	1941 Jan.	1940 Dec.	1940 Jan.	1939 Dec.
Governmental:						
New York City	17	10,380	95*	95	101	92
New Jersey	5	2,285	86*	86*	99	93
N. and S. Carolina	20	2,632	77*	65	76	67
New Orleans	2	3,422	82	79	69	71
San Francisco	3	2,255	104	99	98	95
St. Paul	1	850	69	69	62	62
Chicago	2	3,500	92*	86	92	88
Total[4]	50	25,324	86*	83*	85	81
Nongovernmental:						
New York City[3]	70	16,526	69*	69	75	71
New Jersey	56	8,111	73*	73*	75	66
N. & S. Carolina	109	7,705	68*	61	71	63
New Orleans	6	1,233	75*	68*	82	67
San Francisco	16	3,178	80	78	76	71
St. Paul	9	1,134	85	74	78	77
Chicago	13	2,591	75*	65	68	62
Cleveland	4	800	83*	73	80	74
Total[4]	283	41,278	76*	70*	76	69

[1]Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. [2]Excluding bassinets, usually. [3]General hospitals only. [4]Occupancy totals are unweighted averages. *Preliminary report. Complete occupancy figures for January 1933 to November 1939 are given on page 1026 of The Nineteenth Hospital Yearbook.



More Than $14,000,000 in Hospital Building Projects Is Reported

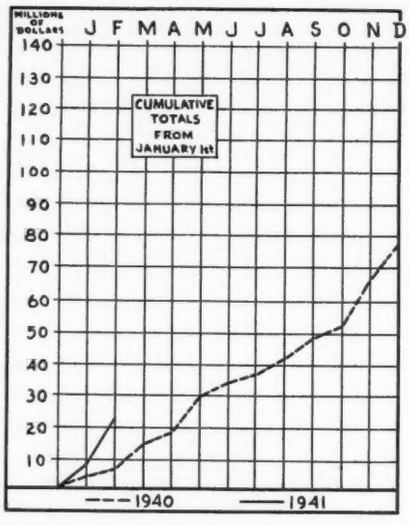
Occupancy in the nongovernmental general hospitals rose from 70 per cent in December to 76 per cent in January, which equaled the record-breaking occupancy of January 1940. In 1939 the January figure was 72 per cent, in 1938 it was 72 per cent and in 1935 it was 60 per cent.

In the governmental general hospitals the preliminary figures indicate an occupancy of 86 per cent which is one point higher than last year, just equal to 1939 and three points above 1938. In 1935, however, these hospitals were crowded with an occupancy of 90 per cent.

From January 13 to February 10 there was a total of 81 new hospital construction projects reported. Only 62 of these gave cost figures, however, which amounted to $13,195,156. However, there were six additional projects that had previously been reported without costs on which the cost data are now available. They totaled $1,185,000, giving a grand total of $14,380,156.

Since the first of the year, therefore, the total of new building projects reported comes to $22,572,836. This is the largest amount reported in the first two months of any year since the present records were started in 1934.

HOSPITAL CONSTRUCTION



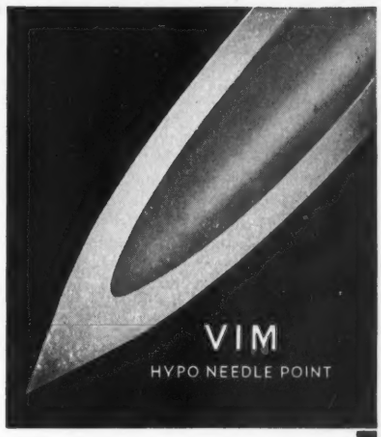
Of the 81 new projects first reported this month, 29 are new hospitals only 12 of which gave costs. These costs came to $8,305,000. There is a considerable number of Army hospitals in this group for which cost figures are not yet available. There were 42 additions to existing hospitals in the current month and 40 of these are to cost $4,183,000. Six alteration jobs will cost $365,000 and four nurses' homes will cost $342,000.

The general wholesale price index of the *New York Journal of Commerce* dropped from 83.3 on January 18 to 81.4 on February 1 and then advanced to 82.6 on February 15. General food prices dropped from 72.2 to 70.1 and grain prices dropped more sharply from 68.6 to 64.1. Textile, fuel and building material prices showed almost no change during the period and ended at 75.6, 85.6 and 112.8, respectively. (These indexes are on the basis of 1927-29 prices as 100 per cent.) The price index for drugs and fine chemicals, as compiled by the *Oil, Paint and Drug Reporter,* advanced from 205.9 to 206.6. (August 1, 1914 prices as 100 per cent.)

The cost of living of wage earners' families in the United States in January was slightly higher than in December, according to the National Industrial Conference Board. In general, the cost of living index at 86 (1923 as 100 per cent) in January has varied little during the last three years. Rises in food prices and in rents, the board reported, were responsible for increased living costs.

Did You Say—
"A sharp point cuts needle costs?"

Yes, I said— "A sharp point cuts needle costs."



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SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Alloys F. Branton, M.D., Willmar Hospital, Willmar, Minn.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William J. Donnelly, Princeton Hospital, Princeton, N. J., and others

Charges for Supplies

Question: If doctors on the staff examine and treat private patients in the hospital office, is it usual to charge the doctor or the patient for material used if such material is supplied by the hospital or does the hospital contribute it? (This might include gauze, adhesive, use of instruments and, perhaps, use of nurses' time.)—R. C., N. J.

ANSWER: Unless arrangements have been made with the doctor to the contrary, it is our custom, when a private patient is seen in the hospital office, to charge him for material used. The fee is based upon the value of material used and time consumed; the minimum fee is 50 cents. However, no charge is made if the office is used for consultation only.—ADA BELLE MCCLEERY, R.N.

Rates for Indigents

Question: What can hospitals do to offset the common impression that townships and other governing agencies should have reduced rates for their indigent patients? Why should they not pay the full cost of hospitalization when their indigents are cared for in hospitals, especially hospitals outside their taxing divisions? Why should the paying patient pay exorbitant costs when others receive hospitalization for less than cost? Why should the citizens of the community be expected to meet the deficit of the hospital when governing bodies of other municipalities do not meet their proportion of the costs of operating the hospital?—N. R., Ohio.

ANSWER: The answer to your series of questions concerning the basis for payment to hospitals by governing agencies for the care of their indigent could well be the subject of several complete articles. The vital interests of both the hospital and the municipality require that this frequently troublesome matter be given thorough consideration, keeping in mind that it is a mutual problem.

What do you mean by full cost of hospitalization? Do you mean the actual cost to the hospital based on a study or do you mean the established rate for services given the indigent ward patient which will frequently, if not always, be less than cost?

The wording of your question, "Why should the paying patient pay exorbitant costs when others receive hospitalization for less than cost?" leads one to believe that you feel private patients are being charged exorbitant rates. The hospital is entitled to, and should, charge the private paying patient more than it costs the hospital for such service.

Citizens of the community in which the hospital is located should not, by themselves, be expected to meet the deficit of a hospital when this hospital serves other communities. Appeals for funds should be made to all of the communities that normally use the hospital.

To get back to the original question, I feel that accurate costs, which can be presented in an easily understood way to a governing agency, is the most important factor in helping these bodies appreciate this problem. I do not think, however, that hospitals should expect to receive from municipalities or other governing bodies the actual cost involved in caring for indigent patients. The question would quite properly arise whether an institution receiving full cost for this service should be allowed continued tax exemption.

In conclusion, all discussions between the hospital and the governing agency should be conducted frankly and in a spirit of mutual cooperation.—WILLIAM J. DONNELLY.

Permission to View Operations

Question: Should the surgeon or the hospital superintendent determine whether a visitor may be allowed to view an operation?—O.S., Tenn.

ANSWER: The superintendent of the hospital should make this decision. Any extraordinary reason for violating the primary rule of "no visitors" in the operating room should be discussed by the surgeon with the superintendent of the hospital for a sensible decision as to special permit to view an operation.—LEE C. GAMMILL.

Preparation of Gruel

Question: How may whole wheat flour be prepared for cooked cereal? What is the cooking time and what vitamins are in whole wheat flour?—R. P., Wis.

ANSWER: Flour is classed a cereal but is not used essentially as a breakfast cereal, as we speak of it. Any cereal grain ground to a soft powder is called flour. Several flours on the market (arrowroot, barley, wheat, oat, rice) are chiefly used in making the gruels and cereal waters that also are called cereals and are used as food for the sick and for infants.

Fine cereals and flours must be mixed first with cold water before adding them to boiling water. Whole wheat flour may be used in this way but the result is more like a cereal jelly than a breakfast cereal. It should be cooked directly over flame for about five minutes and then over boiling water for from twenty to thirty minutes.

Whole wheat flour contains vitamins A, B_1 and G.—DOROTHY DEHART.

Wall Color for Surgery

Question: We are considering painting our operating room. Linoleum in the room is green and black. There are windows on the north. According to modern trends of painting in hospitals, what colors would you suggest we use?—H. S., Kan.

ANSWER: According to the best authority it seems desirable to paint the hospital operating room in a soft tone of blue-green. White walls are undesirable inasmuch as they tend to blind the eye. The colored wall not only affords relief from glare but also complements the hue of blood and betters the acuity of the surgeon's vision.—FABER BIRREN.

Consent for Operation on Minor

Question: Is it necessary to obtain the signatures of both parents for operation upon a minor?—M. B., Pa.

ANSWER: The law implies a contract or promise on the part of the father to pay for necessaries furnished to his child. Hospital care and medical services for children are classified as "necessaries," but the term is not confined to such needs alone. The father of an infant child is the natural guardian and is entitled to the child's care and custody. Since this is so, the father would be the one to consent to the operation upon the child, unless he is dead or has abandoned the mother and child, in which case the mother takes the place of the father.—EMANUEL HAYT.

Getting Doctors to Cooperate

Question: How may brotherly love and cooperation be fostered among four physicians in a community of 5000 where patients are constantly shifting from one physician to another?—M. M. W., New York.

ANSWER: It is hard to change human nature when it comes to physicians. Perhaps it would be better to induce a few new physicians who would cooperate to come into the community. The superintendent will have to take leadership in getting the four doctors together and show them how to cooperate. Luncheon or dinner meetings are helpful to promote better understanding and consequent cooperation. A superintendent with good personality and tactful persistence might be able to win over each physician to a rational attitude of cooperation.—MALCOLM T. MACEACHERN, M.D.

LOOKING FORWARD

Inter-American Cooperation

THERE is now manifest an earnest effort to establish closer relationships among the hospitals of the Western Hemisphere. Present sentiment is to convert expressions of well-meaning intentions into tangible action that will tend to promote inter-American relationships based on an intellectual attitude of mutual respect and understanding of all parties. The progress so far made implies a determination to build soundly so that the resulting structure may endure and be proudly perpetuated by future generations. The hospitals of the United States and Canada welcome such efforts.

Inter-American hospital relations should be what the words clearly imply—relations that are beneficial to all hospitals of the Americas, irrespective of their classification or ownership. In cultivating such relations our enthusiasm should not be allowed to lead us into unwise actions. Our main concern should be to strengthen a cooperative program to unite hospital people of the Western Hemisphere in this great human endeavor.

Several lessons can be learned from the experience of those who participated in the recent Inter-American Institute for Hospital Administrators at Puerto Rico. It was the opinion of several participants, for example, that the air of informality that prevailed at the institute was one of the major factors in its success. Had those in attendance officially represented governmental agencies or even hospital associations, it is doubtful if such free discussion would have prevailed. Each person would have tended to reflect the needs, desires and ambitions of his country from a governmental or organizational standpoint. Since the institute attempted merely to improve the knowledge of the individual administrator, he was free to respond as an individual. This encouraged the development of friendly acquaintance and personal relationships and kept formalities at a minimum.

Therefore, while invitations to participate in the organization of an Inter-American Hospital Association should be extended by the proper authorities to the governmental hospitals of the various republics through their respective presidents, invitations should also go to the other leading hospitals of all the countries concerned, regardless of the auspices under which these institutions operate.

Furthermore, the underlying basis for a cooperative program should be an acceptance of the fact that such a program should have long been in effect and is now urgently needed for the benefits that it can provide to the 11,000 hospitals and to the 270,000,000 people of the Western Hemisphere who look to them for the restoration of health, for aid in public health measures and for the education of those who serve humanity.

The plans for inter-American hospital relationships should be motivated by a reciprocal desire to acquire knowledge. There should be no possible inference or indication that either the North or the South American countries are subservient or dependent upon the other group. While it is true that hospitals play an important rôle in the life of all nations, this cooperative program should not be merely an incidental activity related to national preparedness.

Three Dimensions of Life

AFTER four decades of productive labor in the field of hospital administration, Asa S. Bacon has retired from the active direction of Chicago's Presbyterian Hospital. Thus runs the cold factual statement of the ending of an epoch in the life of one man and of one institution.

Life has more dimensions than mere length, however, and it would be a sorry world indeed if this were not so. To strive merely to live out a span of years would guarantee little of the good to one's fellow men that other of life's dimensions ensure.

Besides length, there is surely breadth to life. The life of the good hospital administrator can never be narrow. The demands made upon him in providing the physical and personnel facilities for the institutional care of the sick are so varied, so kaleidoscopic from day to day, that the alert executive cannot become grooved in his thinking. Moreover, many executives contribute in no little measure to the cultural life of their communities. Here is one who heads his city's lecture forum and there, one who presides at the church organ on Sunday. Surely, then, the length and the

breadth of the life of the community's executive are important factors for good.

There is still another. He who sees and shares the ebb and flow of the physical fortunes of a group of men and women decade after decade, who knows them in health and in disease, cannot but possess that third and all important dimension of life—depth. It is the Bacons, the Washburns, the Peters and the McCleerys who have so shared with their fellow men the good and the bad of life, the buffetings and the successes, the foul weather of illness and the fair skies of good health and who, when they retire for a period of well-earned rest and recreation after a long and honorable institutional service, merit and receive the thanks and sincere appreciation of the whole local community.

This applause is not only local. The whole hospital field, often perhaps too tardy in acclaiming its colleagues, joins in this note of appreciation because the good resulting from lives of such dimensions cannot be confined in one institution or one locality. Salaries may be meager, criticism at times unjust, financial crises too frequent. Yet there are few professions that bring such genuine appreciation from all classes in the community as does that of hospital administration. The lives of these men and women surely are characterized not only by length but by a breadth and a depth that come from an actual participation in the living of others in the community.

First Aid for Medical Records

ANYONE who bothers to put his good ear to the ground may hear troubled murmurs emanating from our smaller hospitals. "Medical records," he will hear, "if only we could get our doctors to keep up their medical records!"

The American College of Surgeons has had a hand in this, its approval program wisely insisting that properly kept clinical records are essential to good hospital administration.

The problem can be solved, but tact and persistence in themselves are rarely sufficient. Most small institutions are finding that trained personnel and specialized equipment are highly desirable if physicians, particularly the older men, are to be cured of indifference and procrastination. Young men on the medical staff have a sounder appreciation of the clinical and research value of well-kept records.

A direct attack on this vexatious problem comes through the employment of a registered medical record librarian. Graduates of courses in medical record-keeping are willing to do double and triple duties so that the hospital of 50 beds or even less can manage to employ a properly trained person.

If, in addition, the hospital will supply the doctors with a dictating machine and the librarian with proper transfer files and storage space the task is simplified. Later, if record and film storage becomes a serious strain on housing facilities, the hospital may purchase a device for photographing patients' records on 16 mm. film.

One may verify the practicality of these suggestions by turning to page 51 where the experiences of 18 small hospitals in handling medical records are summarized.

Why a Cardiology Department?

HEART ailments fall into the general field of internal medicine just as general surgery embraces surgical problems from head to toe. However, branch specialties of internal medicine, such as gastroenterology, diseases of the chest and even cardiology, have grown up principally because of our increasing knowledge and the development of devices that are essential for the completion and confirmation of a diagnosis.

Hospitalization in medical cases means a period of observation, a period of deeper delving and the use of mechanical methods that are not generally found in a doctor's office. Therefore, a hospital should be equipped with an electrocardiograph, an orthodiascopic apparatus and even, in time, a phonocardiograph; above all, it should have a man who is proficient in their use and interpretation.

It is quite obvious why the cardiology department is necessary in the teaching hospital. The student, as well as the staff man, should be aware of the procedures employed in cardiac diagnosis just as he learns to recognize the blood picture peculiar to blood dyscrasias and the implication of an elevated basal metabolism rate. He should be taught in a more leisurely and precise manner by an especially equipped person the various electrographic patterns of diagnostic importance, the fluoroscopic meaning of heart configurations and the recognition of murmurs. Then there is the research necessary for scientific progress which can best be done where there is a complete and systematic integration of all data, both clinical and statistical, under the supervision of a man especially trained in that branch of medicine. The opportunities for follow-up and comparison of such disease entities as coronary occlusion, rheumatic and congenital heart disease, hypertension and myxedema are unique.

The disadvantages of a special department of cardiology lie in the creation of too much dependence on laboratory aids and the "let George do it" attitude. The history and physical findings are of the utmost importance. The electrocardiogram, the orthodiagram and phonocardiogram are valuable adjuncts only and should always be treated as such. For example, no one should make a diagnosis on the electrocardiogram alone and the clinician worthy of the name will never do it.

Thus, a cardiology department finds its justification for inclusion in the modern hospital in its training in methods of precision, its teaching and its research value.

A National Study of Salaries

Orderlies and Ward Aids

ALDEN B. MILLS

WHEN an impending shortage of nurses meets a continuing high rate of occupancy, what will happen? One answer to this question is: increased use of ward aids and orderlies.

Because of the immediacy of this problem, data on salaries of these two groups have been given first place in the second series of salary studies to be published by The MODERN HOSPITAL.

Succeeding articles in this 1941 series will present data on salaries of the following groups: nurse anesthetists, x-ray technicians, laboratory technicians, physical therapy technicians, occupational therapists, housekeeping maids, kitchen maids, chefs or chief cooks, medical record librarians, business managers or chief accountants, laundry managers, laundry workers, medical social service directors, medical social service workers and bookkeepers. Several of the groups will be combined so that all the data can be presented before the end of the year.

In this second salary survey, a total of 1244 schedules that contained information suitable for tabulating was received. Schedules were originally sent to all nongovernmental general hospitals of 20 or more beds. There are 3840 of these in the continental United States, 45 in U. S. possessions and 377 in Canada, or a total of 4262. Thus, there was a 29 per cent reply to the inquiry, which is probably adequate to give a fair cross-section of the practices of all nongovernmental general hospitals in the United States and Canada. Grateful appreciation is hereby expressed to the 1244 hospitals whose courtesy made this series of studies possible.

In all, 1007 hospitals reported salary data for orderlies and ward aids. The other 237 hospitals probably do not employ any persons in this capacity.

The average salary, including the value of maintenance, for orderlies and ward aids in the 1007 hospitals is $74 per month. As will be seen from the accompanying table and map, there is considerable geographic variation in the salaries paid to these employes. The highest of these salaries are found in the Mountain and Pacific states, where the average is $84 per month. The lowest average wage is in the South, where the figure is $63 per month. The East, the Middle West and Canada have averages of $78, $75 and $71, respectively.

Average Total Monthly Salaries* of Orderlies and Ward Aids

Area	Hospital Bed Capacity							
	Under 25	*25-49*	*50-99*	*100-199*	*200-299*	*300-499*	*500 and Over*	*Total*
Eastern	$70**	$79	$77	$78	$76	$81	$83	$78
Middle West	64	66	74	79	80	78	79	75
Southern	52	58	66	64	69	66	59	63
Mountain-Pacific	79	78	78	89	96	90	96	84
Canada	75	67	65	71	88	72	81	71
Total	$63	$68	$73	$76	$79	$78	$82	$74

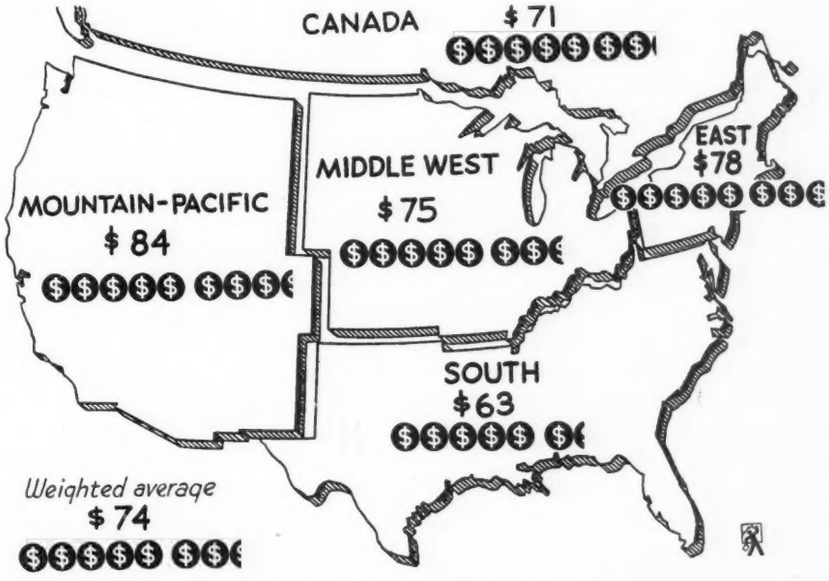
*Including fair value of maintenance.
**Reports from only two hospitals.

Larger institutions, in general, pay higher salaries to their orderlies and ward aids than do smaller hospitals. Although there are some fairly erratic variations in the various regions, the average salary for all areas combined mounts steadily from $63 for orderlies and ward aids working in hospitals of less than 25 beds to $82 in general hospitals of 500 beds and over.

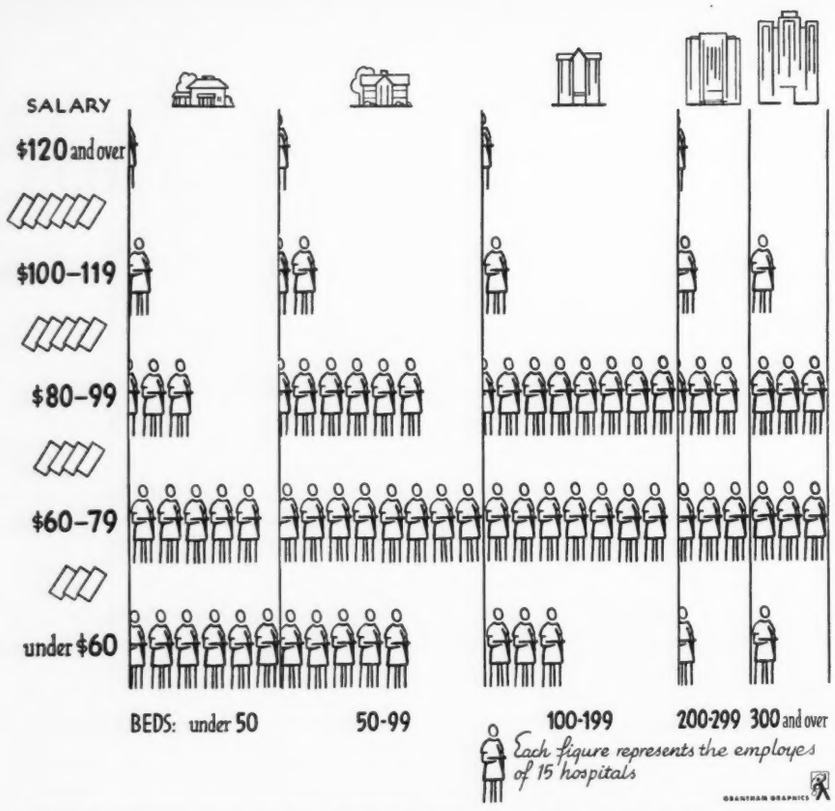
The highest average incomes reported were in 10 hospitals of from 200 to 299 beds in the Mountain and Pacific states and in nine hospitals of 500 beds and over in the same area. These institutions paid an average of $96 per month.

The lowest salaries were reported by 13 hospitals of less than 25 beds in the South, where the average salary was only $52.

Canadian salaries for orderlies and ward aids were more nearly in line with those in the various sections of the United States than were the sal-



Except in the South, the average salaries show only slight variations.



Nearly 70 per cent of the hospitals pay from $60 to $100 per month.

aries of hospital administrators and department heads which were reported in the series published in The MODERN HOSPITAL last year. In every size of hospital except one, the Canadian salary exceeded the salary paid in the South and in four of the seven size groups the Canadian salary exceeded that paid in the Middle West. As in the previous salary study, the figures given have been adjusted to include a fair value for maintenance, which the hospitals that answered the questionnaire were requested to indicate. When they did, the figure they gave was used. When they did not give a figure in terms of dollars but indicated what items were included these items were valued at the following rates: room, $10 per month; one meal per day, $10 per month; two meals per day, $20 per month; three meals per day, $30 per month; laundry, $5 per month; full maintenance, $45 per month.

It is recognized, of course, that no such valuation for maintenance can be entirely accurate in every instance. Fortunately, most of the hospitals reported a value for maintenance. Inasmuch as such figures are usually based upon the local cost and standard of living, they are probably fair. If there is any error in the assigning of arbitrary values for maintenance (and such error would be small), it probably results in too high a figure.

Unfortunately, the questionnaire was drawn up to include orderlies and ward aids in one category. In certain instances the reporting hospitals thoughtfully gave separate figures for the two groups. In such cases it was found that the orderlies were nearly always paid a little more than the ward aids. Since much of their work is similar, this probably reflects a difference based upon the larger financial responsibilities customarily carried by a man or the larger number of opportunities for employment available to him. Too few hospitals, however, made separate reports to justify tabulating the figures separately. For those hospitals giving two different figures, the average was used.

As is true of many hospital positions, there is no uniform definition of duties of an orderly or ward aid. In some institutions, people may be employed for these positions without having had any previous experience or training whatsoever. In other hospitals, a course of training is provided.

Only one state, New York, requires licenses of this class of employe. In New York all "practical" nurses must have a minimum of training or experience to practice, even under supervision in hospitals. Several training programs have been set up in New York City and elsewhere in the state to provide training that meets the legal requirements.

A considerably greater degree of uniformity in terminology and in job assignments could be achieved if all hospitals would study and apply, insofar as is possible, the terms and definitions contained in the report by the A.H.A. committee on personnel relations entitled "Job Specifications for a Hospital Organization."

Employes Paid in Cash

THE custom of paying hospital employes in part by giving them meals, room and laundry has had much to do with the large turnover in personnel. With this in mind, several years ago the trustees of Alameda County Hospitals, Oakland, Calif., determined to pay hospital employes on the same basis as employes in other lines of business were paid. It took several years to accomplish this but today every regular hospital employe is paid his entire salary in cash. By comparison, the salaries will meet the standard paid other employes in the community. Kitchen employes are paid $10 less per month to cover the cost of their food. When other employes receive meals they pay for them, oftentimes in advance on a monthly basis.

The hospital launders all uniforms without charge but no other laundry service is supplied. Students in the school of nursing, interns and resident physicians, as well as students in the laboratory and in the diet kitchens, receive full maintenance, including laundry.

This plan has been more or less in operation for five years and the results are excellent. The employes are happy, the turnover has been greatly reduced and friction and discontent seem to have disappeared. —BENJAMIN W. BLACK, M.D., *Alameda County Institutions, Oakland, Calif.*

Sawdust Beds—

Summary of Seven Years' Experience

HADASSAH M. HOFMANN, R.N.

Matron, Hamilton County Home and Chronic Disease Hospital, Cincinnati

MANY perplexing situations are met with in bedside nursing and one problem that requires a great amount of understanding, diligence and persistence arises in efforts to prevent or to treat bedsores.

A few hours of neglect or careless handling by an indifferent person may cause months of needless suffering and additional expenditure to the patient and may create unnecessary extra work for nurse and attendant. It is only with cautious and vigilant handling that adverse circumstances can be coped with successfully. Because this difficult problem exists in all institutions, this summary of our experiences with sawdust beds is presented.

Hamilton County Home and Chronic Disease Hospital, Cincinnati, approves the use of sawdust beds as a measure for preventing and treating bedsores.

The Hamilton County Home and Chronic Disease Hospital in Cincinnati houses more than 1000 patients. The institution offers care specifically to the chronically ill, the aged and the infirm, and a large percentage of our patients have little resistance and less vitality in their body structure. Certainly, there is no better field for the development of bedsores than in these unfortunate individuals who look to us for aid.

The sawdust bed has for its framework the head, foot and legs of a standard bed, fitted with rubber casters. The bed, or body, consists of a crib made of white pine or cypress wood. The inside measurements are: length, 7 feet; width, 32 inches, and depth, 15 inches. The joints of the crib are glued together during construction to prevent seepage of sawdust. These beds are made for our use in our carpenter shop and the sawdust is delivered to us from the mill either by the barrel or by the sack.

Sawdust made from white pine or any soft wood is sifted to remove splinters and is placed evenly in the crib to the depth of about 8 inches. A quilted pad or a folded draw sheet, 25 by 30 inches, is placed at the head end of the bed and the pillows are put on it. A sheet, a spread and a blanket, if necessary, are placed on the bed as covering. These may be pinned or tied to the foot of the bed to prevent their slipping to the floor. The covers are fan-folded and the bed is ready.

The question of cleanliness may arise. The sawdust comes from the inside of boards; it is heated to a high degree of temperature in the process of sawing and is carefully handled, which makes it clean, if not free from bacteria. Taking everything into consideration it is as clean as an ordinary bed. The sawdust used is white pine or other soft wood because hard wood is irritating and walnut stains when the patient perspires.

The patient is placed directly upon the sawdust (no lower sheet is used) and is able to move from side to side as in an ordinary bed. A backrest or a chair used as a backrest may be placed in the bed during meal time or for a change of position. A wooden tray stand may be placed across the bed for the food tray at meal time, for writing, for handicraft work or for any work the patient desires to do.

If the patient has an open lesion, it is washed daily or as often as is necessary with soap and warm water or with warm normal saline solution. Medications and dressings are not used because these would defeat the purpose of the sawdust beds. When the sawdust becomes soiled from wound discharges or excreta the patient is turned and the soiled sawdust is removed with a scoop or dustpan. The patient is then bathed as needed and fresh sawdust is put into the bed. The soiled sawdust is placed in an airtight galvanized container, the contents of which are later disposed of in the incinerator. A bed bath can be given as if the patient were on an ordinary bed.

Patients find their sawdust beds cool in summer and warm in winter. A chair may be used as a backrest to allow the patient to sit up in bed.

A gauze covering or a mosquito bar material may be draped over the entire bed for protection against flies or other insects.

To care for the bed the sawdust is loosened daily with a wooden paddle and is changed completely every other week or more often, if necessary. Two galvanized cans, one for soiled sawdust and the other for fresh sawdust, are placed on dollies and transported from one room to another and to different points in the ward. Between cases, unoccupied beds are cleared of old sawdust, washed with soap and water and permitted to air until they are needed again.

If the patient's condition requires that he be restrained, the procedure is simple. Two small holes, large enough for a sash cord to pass through, are drilled above the level of the sawdust in the crib and a metal hook is placed on the outside of the crib at a lower level but in line with the holes. These holes are placed on either side of the bed approximately in line with wrists and ankles. Wristlets or anklets or both are placed on the patient and the rope is passed through the metal attachment on the strap and through the holes made on the side of the crib and is tied securely to the hooks on the outside of the crib. This permits the arms and legs to remain by the side of the body and eliminates any excess strain.

The types of cases that profit most from the use of the sawdust beds are: incontinence, bedsores, rectal fistula and vesicovaginal fistula.

Let us consider, for example, an incontinent patient who has been placed upon an ordinary bed with a rubber draw sheet and a muslin draw sheet. If the case is bad, that bed will have to be changed from 15 to 20 times within the period of twenty-four hours if the patient is to be kept clean. Even then, the patient is lying most of the time in a soiled bed and, since moisture and heat are the best mediums for the growth of bacteria, it is easy to comprehend that a bedsore will soon develop if there is a break in the tissues. Placing a dressing over the lesion only helps the bacteria to thrive.

The patient in a sawdust bed presents a different picture. All moisture is rapidly absorbed by the sawdust and the patient is lying at all times in a dry bed. There is a certain amount of ventilation through the sawdust, which allows the body heat to escape. Cooler air is permitted to reach the wound every time the patient turns and there is just enough irritation in soft sawdust to stimulate granulation in the wound. Bedsores with no treatment other than washing with soap and warm water or warm normal saline solution heal like magic in a sawdust bed. No medical properties are attributed to the sawdust; the treatment is a mere matter of physics.

With an ordinary bed there are skin lesions that must be painted with mercurochrome, gentian violet or other medications that are difficult to handle because they ruin the linen. These stains are almost impossible to remove and cause an extra amount of work.

The advantages we have found in the use of sawdust beds may be summarized as follows:

1. They are comfortable and patients like them so well that they frequently ask to remain in the sawdust bed.
2. They are cool in the summer and can be made warm and snug during the winter months.
3. They serve to keep the open wards clean and to eliminate odors.
4. They are economical because they save linen, laundry, medications and dressings.
5. They are labor saving; it is harder to change an entire bed and wash soiled linen than it is to remove a few scoops of sawdust and replace them with fresh sawdust.

The Hamilton County Home and Chronic Disease Hospital has used the sawdust beds for the last seven years. They were introduced as a routine procedure for the care of bedsores under the direction and supervision of the superintendent, Dr. Charles A. Neal, who is also active in public health and social welfare programs. At present there are 24 sawdust beds in constant use in this institution and they have given excellent results.

The bed did not originate in our hospital. It is believed that sawdust beds were first used in an institution for the mentally ill somewhere in Indiana. They are being used in many other institutions with most gratifying results.

The principal objection to this type of bed comes not from the patient but from friends and relatives who at first think that barbaric and abnormal treatment is being extended to their loved ones. They are resentful until conditions are explained and they see for themselves the progress that is made by the patient.

That Problem of Medical Records

How 18 Hospitals Solve It

MOST pressing of small hospital problems, judging from the editors' correspondence, is how to persuade physicians to write up their medical records. It is a bugaboo of large hospitals, too, but apparently the problem may assume nightmarish proportions in the smaller institutions.

Aid and comfort to perplexed administrators may result from some of the replies to a questionnaire sent out to a number of institutions of from 25 to 150 beds. Questionnaires were sent only to hospitals believed to have medical record librarians. In some cases the administrators replied; in others, the medical record librarians.

Let's see how these hospitals meet the situation.

• FRANCES RUTLAND, *McCall Hospital, Rome, Ga. (73 beds):* We found that physicians could not find time to write adequate records but did not object to the hospital's putting someone on a salary to examine all patients and to write up the medical records. This position is given to a physician with the understanding that he will have an office in the hospital and can do outside work. This is working out well for us. In the last eight years several local boys have completed their medical schooling and have come home to practice. Doctor Harris, who is now doing the work, is the third to fill this place. He uses a dictating machine for the history and physical examination. All other records are either dictated to the record librarian or put on the dictating machine by the attending physician.

• DR. C. G. SALSBURY, *Sage Memorial Hospital, Ganado, Ariz. (150 beds):* Deficiency slips showing all records uncompleted at midnight are placed on my desk each morning. These are initialed and returned to those responsible for the particular part of the chart. This is usually sufficient. If not, a note or an interview keeps the slate clean. Records must be kept up to date and progress notes must be written at least twice a week; oftener, of course, for patients in serious condition.

• SISTER M. LAURENCE, R.S.M., *Mercy Hospital, Nampa, Ida. (70 beds):* Our medical staff charges each member 10 cents for every unwritten record. This is collected at the regular staff meeting. The results are fair. Some members have to pay $4 or $5 every month.

• MABEL RYCROFT ARMIT, R.R.L., *Valley Baptist Hospital, Harlingen, Tex. (36 beds):* Study the personality of each doctor. Know his idiosyncrasies. Never drive. Never nag. Use diplomacy and controlled determination. Never ask a doctor to complete charts without placing at his disposal every possible assistance even though that means sacrifice of time and effort. Always maintain an unobtrusive but alert personality. Learn to think with the doctors, never against them. Never question their decisions. Never lower professional standards. Never release doctors from responsibilities for records which they alone can assume.

• HARRY C. SMITH, *Manchester Memorial Hospital, Manchester, Conn. (55 beds):* We have a record committee made up of two doctors. All staff men take turns and each serves for two years. Every month they go over the previous month's charts, checking all histories to see that they are in order. Delinquent histories are reported at the monthly staff meetings. Any questions pertaining to their writing can also be discussed at this time.

• RUTH FLOYD, R.R.L., *Rowan Memorial Hospital, Salisbury, N. C. (113 beds):* We have tried the threat of asking doctors to resign from the staff if they are delinquent with histories for a period of more than a stated number of months. This has worked fairly well. I find that it is also a matter of pride with some doctors and you can appeal to this side of their character to obtain the desired results.

• MARJORIE LARSON, R.R.L., *Ross General Hospital, Ross, Calif. (88 beds):* Perseverance, watchful waiting and even a little nagging on the part of the record librarian are necessary. Recently the staff voted to fine delinquent physicians 50 cents a record on records a month old, then $1 each after that. One of our three delinquents is still delinquent. The other two are slowly waking up to the fact that $15 or $20 a month is quite a price for procrastination.

• L. R. FAUST, *Community Health Center of Branch County, Coldwater, Mich. (52 beds):* Our staff by-laws, written by the staff, provide that any physician who is more than thirty days in arrears with his records shall automatically be suspended from use of the hospital facilities until such records are brought up to date. Our trustees insist that this be adhered to without deviation. Results obtained are good. Certain occasions demand some elasticity. The only exception is written approval from one of a committee of three board members to whom a physician may appeal. This clause has been in operation about two months. Time will tell as to its effect on physicians, patients and hospital.

• VIRGINIA FARRY, *Conway Hospital, Conway, S. C. (66 beds):* If the doctor is behind in his records, the librarian should work with him until he has caught up. I do not mean that she should give bedside service to the physicians for dictation. If they are still delinquent the delinquency should be reported to the superintendent and, if he fails to get cooperation, the board of directors should be informed.

• OLGA BIDNE, *Decorah Hospital, Decorah, Iowa (25 beds):* Even a 25 bed hospital, such as ours, should employ a medical record librarian if it hopes to keep records up to date.

• Margaret A. Meek, *Culver Hospital, Crawfordsville, Ind. (60 beds):* The hospital should give physicians every facility and aid in obtaining their records. A medical stenographer should be available at all times.

• S. Emma Fitzpatrick, R.R.L., *Exeter Hospital, Exeter, N. H. (59 beds):* First of all, conditions should be ideal. The doctors need a place where their records can be written without disturbance or discomfort. Staff by-laws should include a ruling regarding records and the staff should be made to live up to the by-laws. A good record committee can be of great help.

• Miriam L. Dow, *Franklin County Memorial Hospital, Farmington, Me. (50 beds):* We would find it very difficult if the hospital did not employ a resident physician who is responsible for these records. The younger staff men give better cooperation than the older men give.

• Ruby Daniels, *Takoma Hospital and Sanitarium, Greeneville, Tenn. (58 beds):* We have a secretary who handles all dictation from the doctors, both letters and medical records.

• Alma J. Stuive, *Community Hospital, Beloit, Kan. (50 beds):* We have better records when we have a resident physician because he writes all the histories; it is then much easier to persuade doctors to sign all records. Without a resident, we have our best success by contacting all physicians and asking them to write histories and physical examinations within twenty-four hours after admission and by having some similar system for progress notes and special records. We offer the services of a medical secretary to a physician who is lax or inclined to postpone writing records.

• Mrs. Claude Taylor, *Garner Hospital, Anniston, Ala. (66 beds):* Two members of our staff are selected each month to make up the chart committee; this committee checks in the chart room and on all the floors. A detailed report on all chart deficiencies is given at the monthly staff meeting. No patient is allowed to go to the operating rooms until the personal history and physical examinations are recorded.

• Marion V. Black, *T. J. Samson Community Hospital, Glasgow, Ky. (59 beds):* The resident writes the history and physical examination on admission and most of the progress notes, the attending physician often adding a notation. The attending physician writes the final diagnosis and signs the record without much, if any, argument.

• George U. Wood, *Peralta Hospital, Oakland, Calif. (145 beds):* In May of last year the problem of incomplete charts was taken to the medical advisory board for solution. The board adopted a resolution stating that a period of thirty days would be given to complete delinquent histories. If histories were not completed in sixty days after that date, the privileges of the hospital would be denied the doctor. A letter giving this information was sent out to each member of the staff with most satisfactory results. Within sixty days all old charts were completed and current histories were well on their way. Since then the superintendent is given a list of delinquent doctors each month; he contacts them by letter or telephone. In only one instance has it been necessary to deny a doctor the privileges of the hospital until he completed his histories. The doctors do not resent this action and the standard of their records has improved considerably owing to the fact that they are dictating cases while the details are still fresh in their minds.

Should Librarian Be Employed?

Question 2 on the questionnaire asked whether hospitals of fewer than 100 beds should employ a record librarian. It further asked whether the small hospital should have a stenographer for the doctors or should expect the librarian to do this work.

Opinion was unanimous that hospitals of between 50 and 100 beds should have a medical record librarian. There is enough work in a 100 bed hospital to keep a record librarian busy without the medical stenography, in the opinion of some administrators and record librarians. Other hospitals of that size expect the record librarian to do the medical stenography.

The 50 bed Franklin County Memorial Hospital expects the medical record librarian to assist with general office work. In the 55 bed Community Hospital of Beloit, Kan., the registered medical record librarian has several other duties and so is not required to take the medical dictation.

The Takoma Hospital and Sanitarium, Greeneville, Tenn., with 58 beds, expects its record librarian to teach some classes and to perform other duties in addition to handling the work of the record room. A stenographer is, therefore, necessary to take the doctors' dictation; otherwise, he may be held up while the librarian is teaching a class or is engaged elsewhere.

Question 3 was concerned with the length of time a small hospital with limited storage space should be expected to keep its clinical records. It asked when records should be transferred to the inactive file, whether nurses' notes should be kept as long as the rest of the record and how long it is necessary to keep x-ray negatives.

Despite limited storage space 14 persons out of the 18 replying to the question expect to keep clinical records indefinitely or permanently. Two others keep them during the patient's lifetime. Two keep them ten years.

Some of the hospitals questioned never transfer records to the inactive file. One institution keeps them in the active file only one year. The majority keep them from five to ten years, a few more designating the five year period than the ten year period. Eighty per cent of those replying keep nurses' notes as long as they keep the record.

As to x-ray negatives seven of 18 hospitals keep them permanently; four keep them from five to ten years; four keep them five years; two keep them two years, and one keeps them three years.

The problem of keeping the records permanently is solved by a device that photographs the record on a 16 mm. film.

Some hospitals have destroyed all films that were inflammable, but since the advent of the safety film expect to keep records indefinitely.

We Made a Movie

EVA ELLEN JANSON

Superintendent
Children's Hospital, Columbus, Ohio

A "still" of the attractive grounds of Children's Hospital in Columbus.

VISUAL EDUCATION has long been considered an effective educational procedure. Until recently, it has been little used in conveying the story of hospital activities to the public.

After our hospital added a new wing, in which we have much larger laboratory quarters, we allocated the former laboratory space to a photography room. The room is located in the north central court on the first floor of the hospital where it is easy to control the light. The laboratory tables were removed, the walls were painted a light green and black curtains were hung. A platform was made by our handy man. This and the chairs were painted black so that a black background could be arranged for all still pictures. Flood lights and camera were then purchased.

Our first attempt at this type of work was still photography, which had been requested by our orthopedic surgeons. Of each child admitted to the hospital for orthopedic surgery we take a preoperative and a postoperative picture. By comparing the two the doctors can see the esthetic results of the operation and the improvement made.

After the negatives are developed the pictures are labeled with the child's name, dispensary number and the date the picture was taken. The photographs are filed away in the dispensary charts for reference upon the child's return to the clinic. The negatives are likewise labeled and filed in a fireproof filing cabinet kept in the photography room.

For the work we prepared one of our hospital aids, a high school graduate who was a little older and more experienced than the average. The visual education equipment salesmen helped her to get acquainted with the mechanics of the machine and then we sent her to the university where she entered an adult education class in amateur photography.

Because the still photographs were able to tell the story of the child's recovery in a concrete way not only were the doctors pleased but the women's board of managers was impressed. The women's board immediately pointed out the public relations value of moving pictures of hospital work. One of our board ladies bought a motion picture camera for us and one of the auxiliaries purchased a projector and screen.

We set out to take pictures of the exterior of the hospital and of the various departments, showing a patient being admitted to the outpatient department; nurses dressing, and weighing patients and taking their temperatures; the various clinics (nose and throat, speech, psychology); x-ray department; formula laboratory; pathology laboratory, and the physiotherapy department. We also included pictures of volunteers entertaining the bed patients.

After we believed we had developed a fairly good moving picture, a committee appointed by the women's board of managers was invited to see it. The reactions of this committee took the form of constructive suggestions.

We cut, spliced and added film and again called the committee to see the picture. At last we had a film that was fairly representative of the hospital activities.

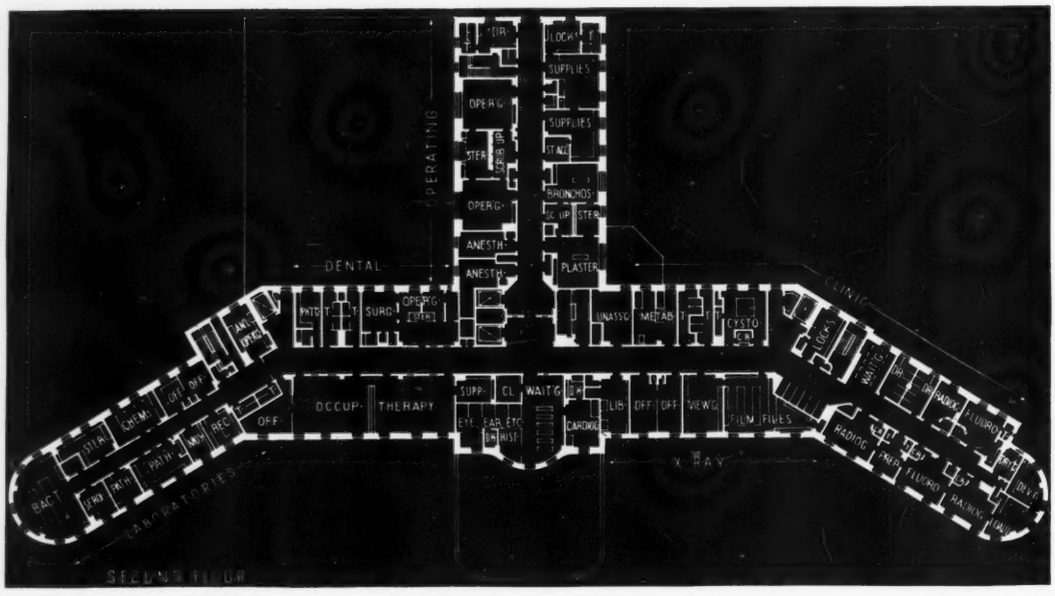
The chairman of the committee sent a letter to the parent-teacher association, luncheon clubs and school principals, telling them of our movie. She said she would arrange to present it at their request and explained that the running time was about thirty minutes.

The people who by this time have seen the film have been enthusiastic about it and we now have more requests for showings than we are in a position to fill.

Let me summarize the essentials we found necessary in preparing and presenting a good picture of our hospital activities.

1. Room.
2. Equipment.
   - Still camera
   - Flood lights
   - Motion picture camera
   - Projector and screen
3. Development of an interest in the picture on the part of the doctors and the board.
4. Solicitation of helpful criticism from hospital auxiliaries.
5. Selection of the right type of person for taking the picture and provision for her proper training.
6. Careful choice of representative hospital activities that photograph well.
7. Previews by a women's lay committee before public presentation.
8. Local publicity on the film's availability to groups that apply.
9. An organization prepared to present the picture when it is called for by some section of the public.

550 Beds for Defense—



Plan of the second floor, which houses the operating rooms, x-ray departments, laboratories, occupational therapy rooms and diagnostic services. One surgery is equipped with air sterilizing units. All plans are reproduced by courtesy of the Architectural Forum.

CONSTRUCTION DETAILS

CONSTRUCTION: Fireproof throughout. Steel skeleton, with concrete and tile floor arches. Walls, 12 inch concrete below grade and 12 inch brick above. Exterior, buff colored face brick with limestone trim and granite steps. Furring of exterior walls, free-standing terra cotta block. Partitions, terra cotta and metal-and-glass. Balconies, reenforced concrete, with iron railings topped by teakwood rails. Windows and doors, steel, mostly double-hung with casements and projected sash in certain special locations. Exterior doors, bronze at main and out-patient entrances, steel elsewhere. Insect screens, bronze. Interior doors, wood, except hollow metal for stairs and elevators.

FLOORING: Lobbies, operating rooms, spaces under beds and borders for corridors, terrazzo. Corridors, offices, x-ray rooms (other than developing suite), assembly room, library, and circulation areas of wards, asphalt tile. Baths, toilets, utility rooms, sterilizing rooms, ceramic mosaic tile. Roofs, quarry tile. Kitchens and related spaces, flint tile.

WALLS: Main lobby, marble. Stair shafts and central kitchen department, structural glazed tile. Assembly room, medical library and superintendent's office, wood veneer. Principal corridors, structural glazed tile wainscots. Toilets, baths, utility rooms, serving kitchens, sterilizing rooms, operating rooms and similar spaces, applied wood tile.

CEILINGS: Generally, painted plaster. Utility rooms, serving kitchens, dishwashing rooms and metabolism rooms, acoustical metal tile.

HEATING: Low pressure steam, with high pressure for sterilizers and certain other equipment. Exposed radiators, except in certain special rooms.

LIGHTING: Smaller wards, semi-indirect. Other wards, suspended globes of special glass giving semi-indirect effect. Individual reading and examination light attached permanently to wall or partitions over every bed. Bactericidal lamps in operating rooms.

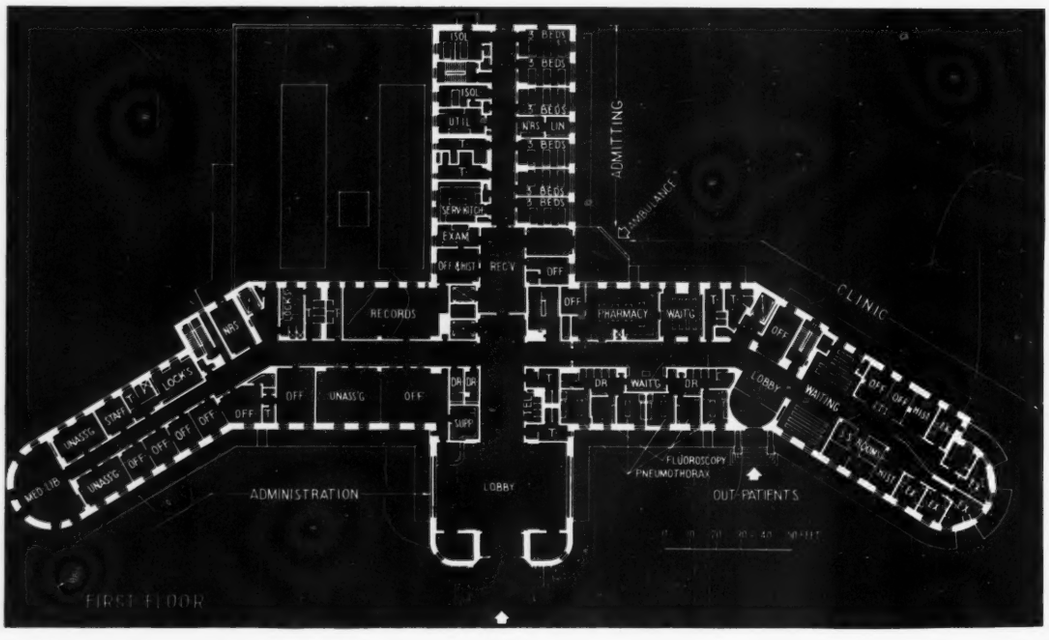
ELEVATORS: Self-leveling, fully automatic.

REFRIGERATION: Laboratory refrigerators, self-contained electric units. All others, brine lines from central refrigerating plant located in power house.

X-RAY: Complete diagnostic service, including radiography, fluoroscopy and cystoscopy.

RADIO: Central system with plugs at every bedside affording choice of three stations. Also used for phonograph records.

COSTS: Without furnishings, approximately $3,100,000. With furnishings, $3,500,000; 45 per cent financed by P.W.A. grant.



The first floor is devoted to offices, pharmacy department, record room and isolation rooms. Plans for the institution were developed by former commissioner of hospitals, Dr. S. S. Goldwater and the commissioner of public works, and completed under the administration of Dr. Willard C. Rappleye.

Against Tuberculosis

EGGERS and HIGGINS
Architects, New York City

WITH the completion of the new Triboro Hospital for Tuberculosis the City of New York has added 550 beds to the municipal defenses against this particular form of illness. This latest link added by Mayor La Guardia to the city's vast hospital chain has come into being on the high western end of the Queens General Hospital property in Jamaica, with which institution it will have underground connections, as well as administrative relations. It will serve the boroughs of Brooklyn, Queens and the Bronx.

Embodying the latest advances in planning and equipment, the plans of the hospital strongly emphasize light and air, which have been achieved by means of glass enclosed solariums, expansive glass areas in the walls of patients' rooms, open balconies and roofs and general spaciousness.

The patients in Triboro Hospital are quartered largely in wards; 40 per cent of them are in 6 bed wards and a like number in 24 bed wards. Most of the remainder are in 2 bed isolation rooms, which have been provided for patients who are critically ill, for postoperative cases and for those who for other reasons must be separated from their fellows.

The third to the seventh floors, inclusive, are typical and the eighth floor has a similar but curtailed layout. The typical floor has two 24 bed wards and a half dozen of the 6 bed variety. The larger wards are subdivided by metal and glass screens, 7 feet high, into three areas of 8 beds each and are for the least advanced cases. The 6 bed wards occur in groups of three and are separated from one another by ceiling-height, metal and glass partitions to limit the travel of coughing sounds. The isolation rooms have separating screens and private toilets and are equipped with water-actuated aspirators for pus removal.

Except in the admitting section every ward opens directly onto a balcony where patients may stroll, relax in wheel chairs or even be placed out in beds to enjoy fresh air and sunshine. During the high sun of summer these balconies, which are cantilevered from the building and require no supporting posts, serve as welcome awnings for the rooms inside; however, they do not exclude the more elusive rays of the low sun of winter.

In addition to the balconies the patients have access to broad, tiled roof areas, partly open and partly covered, which are located on the third, eighth and ninth floors and afford a variety of diverting scenery.

The cheeriness of bright and spacious quarters is particularly important to tuberculous patients, who live in the shadow of a gravely uncertain future. The story heights in Triboro Hospital are a generous 13½ feet, while the main corridors have the rarely encountered width of 10 feet. At a strategic point in each half of every floor a subcorridor leads from the main corridor to an outside window for the sole purpose of providing as much light and ventilation in the interior of the institution as it is possible to obtain.

In a large part of the building the walls, ceilings and cubicle curtains are of a cheerful yellow; metal trim, including metal partitions, is given a light buff color. In certain spaces, such as operating rooms, where glare is taboo, wainscots of dull green tile have been used, with harmonizing shades of green for walls, ceilings and metal work.

Although designed primarily to serve the needs of tuberculous patients efficiently, the Triboro Hospital plan has been worked out also with an eye to that future time when the ravages of this disease will have been so thoroughly checked that this institution can be released for use as a general hospital.

In its general layout the form of the plan represents an effort to obtain the desired floor area on the given plot with the best possible orientation. In its subdivision by floors the building largely follows a conventional pattern. In the basement are the kitchen department, dining rooms for personnel, storage rooms and general service arrangements. The large main kitchen suite is located principally in a one story extension at the rear, thus permitting abundant natural light, which produces a bright, clean atmosphere.

Photograph from Wurts Brothers, New York

The exterior of the building is buff colored face brick with limestone trim. Cantilevered balconies serve as awnings in the summer.

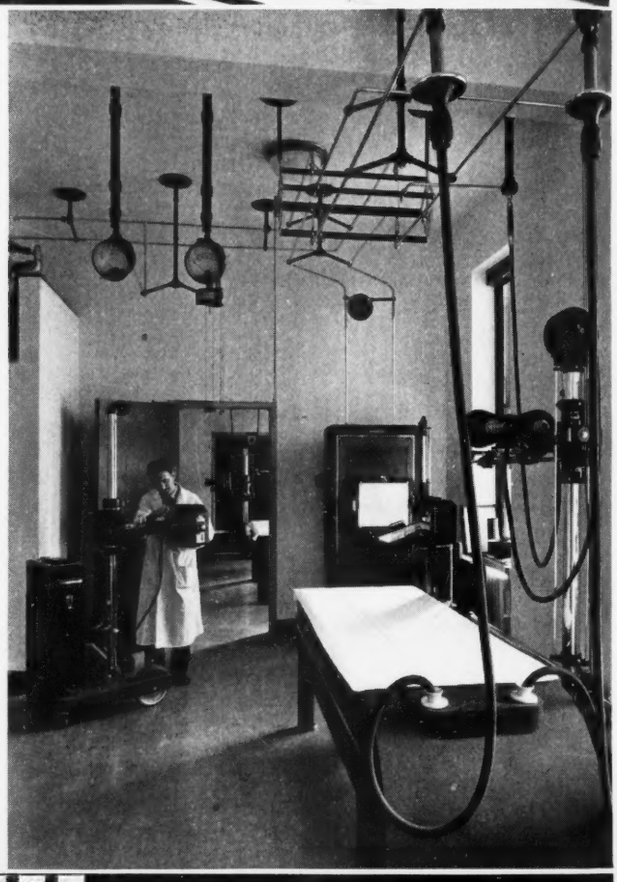
The admitting section is adjacent to the ambulance entrance at the rear of the first floor and contains a complete nursing unit that accommodates 21 beds.

The out-patient department occupies one of the main wings on this floor and includes, among other things, two complete suites for pneumothorax treatment. Each suite comprises a fluoroscopy room and two rooms used interchangeably for pneumothorax and tapping, as well as a dressing room with cubicles and a rest compartment. Also on the first floor are the main entrance lobby, administrative offices and staff library.

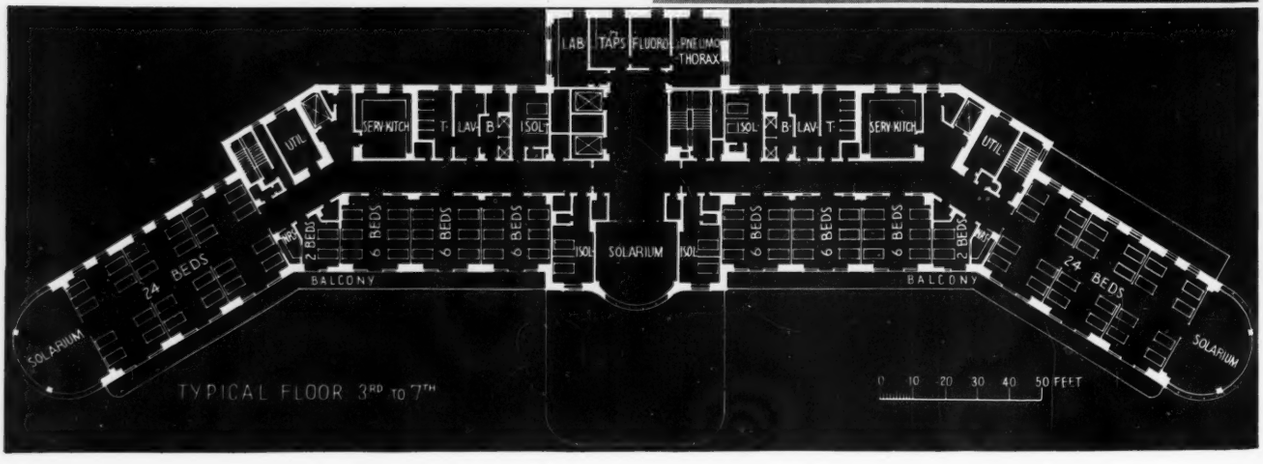
On the second floor are the operating and the x-ray departments; extensive laboratories; occupational therapy rooms; the diagnostic services for cardiography and metabolism, and facilities for dental and ear, nose and throat work. One of the four operating rooms is equipped with a complete air sterilizing installation, consisting of a central fixture attached to the main operating light, six ceiling fixtures and a mobile unit that is used over the instrument table.

Centrally located on every typical floor are a laboratory and a pneumothorax suite similar to those in the out-patient department except that on the patients' floors no dressing or rest facilities are necessary. Aside from this central portion the typical floor is virtually symmetrical and provides identical services in each half. The nurses' station in each half of the plan is so located and arranged as to command a view through the full length of the wards under its control.

The ninth floor—the topmost of the principal floors—is dedicated to

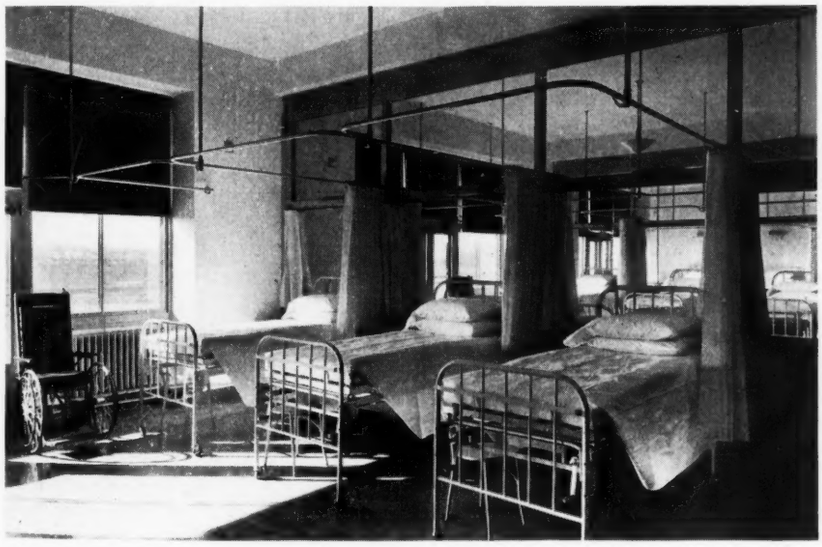


Above: A typical patients' corridor. The unusual width of the halls and the large glass areas in the walls create a feeling of spaciousness. Right: Fluoroscopy room with radiography room beyond. Below: The third to seventh floors are laid out on the same plan. They contain two 24 bed wards as well as six 6 bed wards.



View of the main kitchen, located at the rear of the building, showing part of the serving counter with steam kettles and bake ovens beyond.

The assembly room is provided with a stage, dressing room and a standard motion picture projection unit for the entertainment of the patients.



One of the several groups of 6 bed wards. The wards are separated from each other by metal and glass partitions extending from floor to ceiling.

the ambulant patients, who include a large part of the total register, and to the members of a quite unique group, *i.e.* the day campers. Four large ward-like spaces are designated as "day camps," and to them come convalescent, recently discharged patients who for a certain period of time appear at the hospital each morning, spend the day resting under competent supervision and favorable surroundings and return to their homes in the evening.

On the same floor are a large, bright cafeteria and two pleasant dining rooms, as well as a small auditorium or assembly room, all intended for the pleasure and recreation of patients. The assembly room has a small stage for the presentation of moving pictures, lectures and entertainment of various kinds and is provided with a standard projection room and equipment for sound pictures and stereopticons.

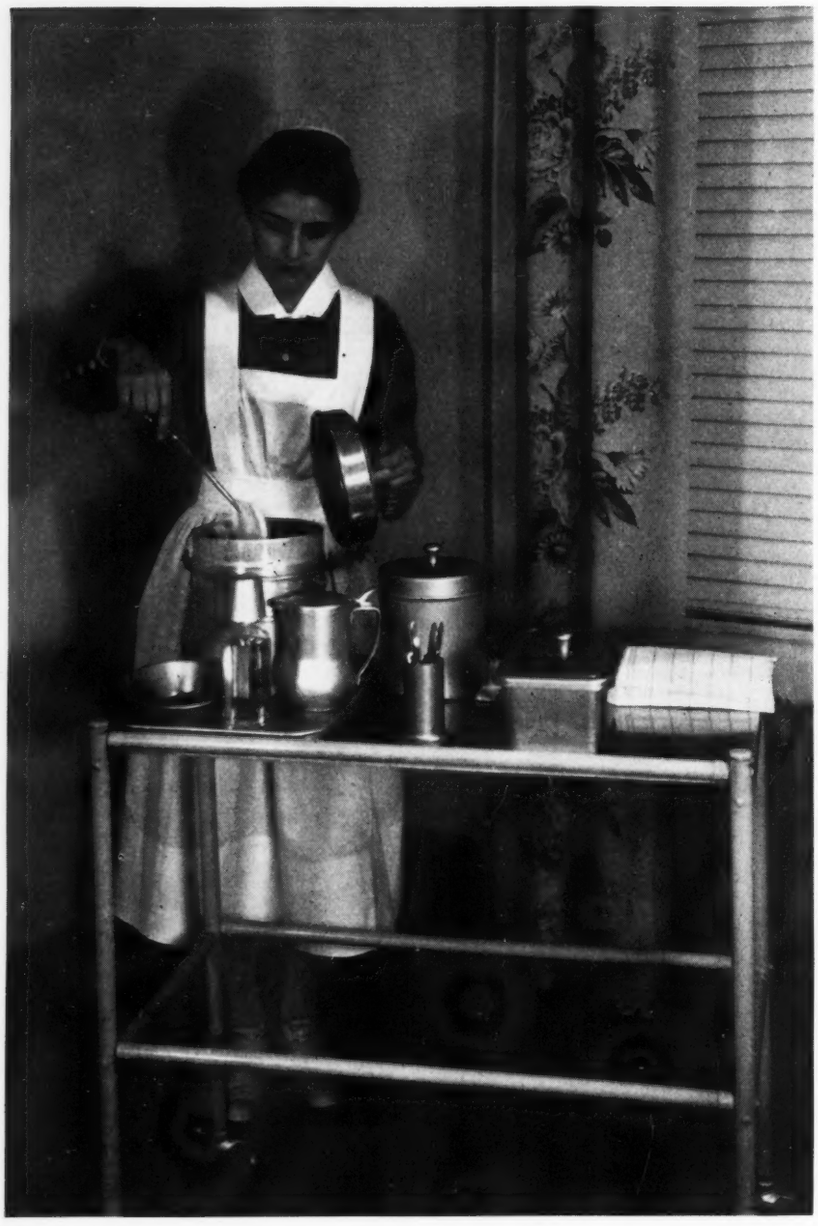
Even the bed-ridden patient has facilities for recreation. Except in extreme cases he is permitted to seek diversion in the radio and in reading. For every bed there is a radio outlet with a pillow type of soft speaker. A special lending library for patients is a boon for all, and from it a book truck makes regular rounds of the patients' rooms bearing volumes that for many are the means of temporary escape from their heavy burden.

The interior finishes of Triboro Hospital have been established according to the customary standards for modern hospitals of the first class. On the exterior the design of the building is a functional expression of the plan and is wholly devoid of ornamentation. The masonry portions of the exterior walls are faced with buff colored brick and with limestone sill courses.

The erection of an institution such as Triboro Hospital at New York City's modest elevation bears witness to the modern school of thought in the treatment of tuberculosis. Many authorities feel that wonders can be accomplished by means of surgical methods, rest, fresh air, relaxation and—last but not least—good food and plenty of it. The traditional high, dry altitude still is held to be desirable, but when necessity eliminates it from consideration the medical profession no longer folds its hands and despairs that "nothing can be done about it."

Hot Compresses Stay Hot

BERNIECE BOIES, R.N.
Assistant Instructor in Practical Arts
St. Luke's Hospital, Chicago



SEVERAL methods and procedures of applying hot compresses have been tried and used at St. Luke's Hospital, Chicago, but none of these methods has proved as acceptable from the standpoint of good nursing care as the compact unit now in use.

The equipment consists of a tray, a double boiler bucket, a pitcher, a kidney basin, a bottle of boric solution with a sprinkler top covered with a sterile aluminum cup, four tissue forceps in a container of 70 per cent alcohol, two containers for sterile dressings and a portable table which can easily be rolled to the patient's bedside.

The aluminum double boiler bucket is the important feature of the unit. It consists of an outer container into which a perforated upper compartment is fitted.

In preparing this bucket for the procedure of applying hot compresses, ¾ quart of sterile water is poured from the sterile pitcher through the perforated compartment of the double boiler. The sterile compresses, which are kept in the round container, are placed in the inner perforated compartment with a lifting forceps and sprinkled with boric acid solution until they are slightly moistened.

The cover is then placed on the bucket and the bucket placed on a gas plate. The water is allowed to boil vigorously for five minutes so that sufficient steam will accumulate in the top compartment of the bucket to steam the compresses thoroughly. The bucket is then placed on the tray and the entire unit is wheeled to the patient's bedside.

The soiled dressing is removed with a forceps and discarded into paper provided for that purpose. The forceps that is used to remove the dressing is discarded into the kidney basin. A second sterile forceps is used for the application of the sterile hot dressing. Wax paper is applied directly over the compress and covered with another sterile dressing. This application is held in place with a binder or bandage.

There are many advantages to be gained from this method of applying hot compresses. In the first place the dressings are never oversaturated with solution and this eliminates the possibility of burning the patient because there is no excessive solution to trickle over the skin. It also lessens the danger of contaminating the compresses, especially when, in some procedures, the compresses are wrung from the solution by the use of forceps or the fingers in order to eliminate excessive moisture.

Then, too, the sterile bucket will keep the compresses hot for a considerable period, thus enabling the nurse to change the dressings of all patients in her assignment in less time because it is not necessary for her to return to the treatment room for more supplies or to reheat the solution.

Moreover, the general appearance of the table with its neat compact arrangement of sterile equipment is in accordance with the principles of aseptic technic, a significant factor in giving good nursing care to patients.

Emphasis on Service

In the Small Hospital Laboratory

J. T. MORRISON, M.D.
Commonwealth Fund
New York City

THERE is a sharp distinction between a laboratory that merely does a perfunctory job of "laboratory work" and one that renders a real service to the community. For the development of a real laboratory service in a small hospital, I consider the methods devised for making its work available and for studying results of greatest importance; of next importance is the selection of technical personnel, and of third importance are its construction and equipment. For purposes of this discussion I propose to take up these three essentials in reverse order.

First, let me establish the setting. Let us visualize a hospital of from 50 to 60 beds located in a community containing between 50,000 and 60,000 people within a radius of 25 miles. Located in the center of this area, the hospital is of the community type and is available to all patients in the area regardless of color, creed or economic status, and to all physicians of the community for the care of their patients. It is administered by a board of trustees and a superintendent. It renders service to both in-patients and out-patients at rates within the economic reach of the majority of the people.

The clinical laboratory is located in the basement of the hospital—a half basement with windows above ground level that give light and ventilation. It was located there so as to be adjacent to the x-ray department since the hospital planned to employ a laboratory technician who was also trained for x-ray work. In this location it is most readily accessible to out-patients and emergency patients requiring either x-ray or laboratory work and it is far enough removed from the hospital rooms so that odors from the use of chemicals are dissipated before reaching the bed patients.

The laboratory is 20 by 14 feet, large enough to permit the distribution of equipment for the various types of work and yet small enough to be efficient. The work bench is wide and extends around three sides of the room. Blood examinations requiring microscopic work can be performed in front of one window; chemical examinations can be performed near one of the sinks; bacteriological work can be done in an incubator in one of the corners.

Beneath the work bench around the walls are cupboards for the storage of equipment and supplies and above it there is one glazed cupboard for special glassware. A small rail shelf above the back of the bench accommodates solutions in immediate use. There is no central desk.

The laboratory is equipped for a wide variety of microscopic chemical and bacteriological work and yet it has purchased only such equipment as can be most effectively used. The basic equipment originally installed in this laboratory cost approximately $650. No provision was made for pathological work, although this would have increased the cost by only $170.

Laboratory work and laboratory service are two entirely different things according to Doctor Morrison, who tells how small hospitals can render real service to the community

At the outset the hospital did not require equipment for the more specialized types of blood and bacteriological examinations, such as carbon dioxide determinations or virus filtration. Later purchase of equipment for making special blood examinations, however, cost approximately only $110, so that the laboratory could have been completely equipped for all types of work, including the pathological, for not more than $930. This, however, does not include two other items which this hospital considered essential, *i.e.* a refrigerator and an autoclave. The refrigerator purchased has a capacity of 3.1 cubic feet and cost $103. It is used for keeping biologicals and culture media. The autoclave is 16 by 24 inches in size, cost approximately $300 and is used for the sterilization of infected material from the operating or isolation rooms, as well as for such steam sterilization as is needed in the laboratory.

The technician employed by the hospital takes her work seriously. She was trained in an approved school for laboratory technicians and subsequently spent some time in postgraduate work as new methods were brought into use. These periods of postgraduate study were made possible by the hospital. She is able to organize her work so that she can perform a thousand laboratory examinations a month and handle the work of the x-ray department also. She is expected to perform such emergency examinations as may be necessary outside of her regular hours and is willing to work with the physician on twenty-four hour service, although every attempt is made by the administration to keep emergency calls at a minimum.

The hospital administration assists the technician in organizing her work by setting up certain regulations and adopting certain procedures. Physicians are requested to admit patients for operation at least 16 hours before the operation is to take place and, at the latest, before 4 o'clock of the preceding day. The hospital has a house physician who is expected to perform urine examinations and blood counts for emergency patients, although he can call on the technician for assistance if the nature of the emergency warrants it. Examinations other than the minimum are usually made by the technician on call.

The technician and house physician or laboratory supervisor rotate

Presented at the New England Hospital Institute, September 1940. The second section of Doctor Morrison's article will appear in the April issue.

for week-end service, as circumstances indicate, so that time off can be arranged. The technician and the house physician in the small hospital, however, are in a position similar to that of the general practitioner with whom they work, in that they are on duty at all times to assume the responsibility for their part of the work of attending patients.

Pathological work, although somewhat in the background, is an essential part of the laboratory service. In my judgment the very minimum of pathological service rendered by the hospital should include the gross and microscopic examination of all tissues removed at operation and at necropsy and the filing of all such reports with the clinical records of the patients.

An ideal pathological service would involve the establishment of a resident pathologist at the hospital to perform these tasks, attend all staff meetings and be available for consultation. This type of service, however, is usually out of reach of the 50 bed hospital and it is necessary to make the best possible arrangement with a near-by pathologist.

Difference Lies in Spirit

The difference between mere laboratory work and a true laboratory service is one of spirit and method. Both are necessary. The best methods will fail if there is no spirit of service to carry them through. But the spirit of laboratory service does not lend itself to discussion while the methods to be employed can be discussed and outlined.

Let us, therefore, give our attention to the methods of developing a laboratory service, considering the methods of making the service freely available, of supplying it with an interpreter and of reporting its results to staff members in a readily understandable form and to the administration in terms that indicate quality of service.

In this community hospital the laboratory service is considered an essential part of hospital care on a par with the nursing or dietary service. To that end an inclusive, or fixed, rate has been set up for in-patients who stay longer than three days. Under this plan no extra charges are made for any laboratory or pathological work performed, regardless of the amount that may be required. No separate accounting of laboratory income is necessary and laboratory costs are considered a part of hospital costs. A patient who is admitted to the hospital is assured at the time of admission that the total amount of his hospital bill will be based on the estimated length of stay and will know that there will be no additional charges to make the bill larger than anticipated.

Anyone who has been a patient in a hospital where special charges were added to the room and board rates and has been presented with a bill considerably larger than might have been expected from the rates quoted can well imagine the good will that the hospital gains in the community by being able to quote a fixed and final rate.

It has been argued that an inclusive rate for laboratory service is out of the question inasmuch as the laboratory is one of the money-making departments of the hospital. My answer is that, if the revenue derived from the laboratory is used to offset losses incurred from patients who cannot pay for their hospitalization or who pay less than cost, the burden of free service is then borne by a few persons in the community who are to a certain extent penalized for requiring laboratory work.

It is my feeling that the cost of hospitalizing patients who are unable to pay should be distributed over the community by other means. Moreover, the maintenance of a laboratory for the purpose of producing revenue keeps the charges at such a figure that both patients and physicians will too often dispense with necessary laboratory service rather than assume the burden of paying for it.

Under the fixed rate system the physician is assured that in getting full laboratory service he is not increasing the cost to his patient. He can, therefore, proceed without hesitancy to take such steps as will give him a more accurate picture of the disease condition present and will check his therapy.

This may immediately raise a question as to the possibility that the laboratory privileges will be abused by ill-considered requests for laboratory examination. In the experience of the hospital under discussion such has not been the case. Some abuse did occur when the rates first went into effect but, because knowledge of the value of the laboratory increased through its use and because the staff in conference agreed to require a tentative diagnosis before other than routine laboratory work was undertaken, the abuse ceased.

A laugh in staff meeting from the other members of the staff proved to be of as much value in checking the abuse as silence or a critical comment in the event of insufficient laboratory evidence. In fact, the abuse of the service in this hospital never reached a point where it equaled the seriousness of failure to use the laboratory to the fullest advantage, which was sometimes evident under the plan of charging for individual laboratory examinations.

I do not see how laboratory service can be considered other than an essential part of hospital service and I believe that any fancied loss of revenue is more than offset by the profits in good will that will be derived from satisfied patients.

Moderate Fee for Out-Patients

For hospital out-patients, the use of the laboratory is stimulated by an arrangement whereby a moderate charge is made for a single examination with a proportionately lower maximum charge for several. We have found as the average experience in 10 comparable hospitals that the cost of a laboratory examination is slightly less than 16 cents. Although this figure does not take into consideration interest on the investment or the items of replacement, it is so low that we may safely assume these charges made to ambulatory patients more than cover the total cost. At the same time they are well within reach of the average man's ability to pay.

The laboratory is available also for the work of the public health authorities of the community as is necessary. The hospital in question has an arrangement with the local public health department whereby for a stated monthly sum the public health examinations are made. These include an occasional Kahn test; dark-field examinations, for which the laboratory is equipped, and other tests that are needed in the public health clinics. All Wassermanns for the health department, as well as for the hospital patients, are sent to the state laboratory.

Guide to Good Nursing

for the Smaller Sized Hospital

MARGERY J. MacLACHLAN, R.N.

Director, School of Nursing, Decatur and Macon County Hospital, Decatur, Ill.

THE "Curriculum Guide for Schools of Nursing" has been available since its first printing in July 1937. As Sally Johnson of Massachusetts General Hospital, Boston, said at the 1937 meeting of the National League of Nursing Education: "We have passed through the stage of apprehension and fear, and some among us have shaken our heads and even snorted; certain ones among us have even shown the whites of our eyes. But we have not run away."

Putting the Cart Before the Horse

Those of us who direct small schools of nursing have regarded the Curriculum Guide with the greatest apprehension and fear, but we have not run away. A great deal of this apprehension has persisted because in trying to get somewhere in the use of the Guide we have been pushing the cart around instead of directing the horse. After a ten or twelve hour day of trying to get students and doctors to classes, of filling emergencies in various departments of the hospital from the diet kitchen to the switchboard, we have sprawled out on our beds and picked up the Guide and thumbed it through.

We were tired and part 1 looked like pretty heavy reading so we went on to part 2—and there was chemistry! We hunted with great apprehension for time allotment. We were giving forty-five hours, which the state required, and to our horror we found: "Eighty to ninety hours, to be arranged in two or three hour periods, are recommended for students who have had no previous college chemistry." We gave a groan and went on through part 2 in the same way. That first year, we "adopted" the new Curriculum Guide by shoving in a few more class hours.

One thing that alarmed us in our hasty perusal of part 2 was the presence of some new names for courses of study and the absence of names that were still listed in our state rules and regulations for accredited schools of nursing. This worried us to such an extent that some of us juggled our budgets and got away to a state or a national meeting to find out what it was all about. When we returned we ordered several more copies of the Guide, placed them in the hands of our supervisors and instructors and set about reconstructing the courses of study. The result was a shifting around of course content and the application of the new names.

Although we were teaching venereal diseases with communicable diseases instead of the old course in "skin and venereal," the actual presentation of subject matter was pretty much the same old story in the same old way. We realized that we had failed to develop the curriculum on the assumption that "social, preventive and teaching elements should be taught in all good nursing schools." We also came to the realization that we could not do it alone, that everyone participating in the teaching program and concerned with establishing the policies of the school must have a clear knowledge and appreciation of the philosophy and aims of nursing education. This is what we are working on today, *i.e.* educating our boards and our nursing school committees so they will make possible the realization of our present aims in nursing education.

In the nursing school of Decatur and Macon County Hospital, Decatur, Ill., we have as chairman of our nursing school committee the dean of our local university. His special function is to assist the director of the school of nursing in interpreting the philosophy and aims of nursing education to the rest of the committee and to the hospital board; he also acts as a consultant on all educational problems. His influence with the board of directors of the hospital has been invaluable in making it see the necessity of a graduate staff in order to put the desired curriculum into effect. Our chairman has studied nursing education and believes that the realization of its aims as stated in the Curriculum Guide is essential for an adequate nursing service for the community.

We also have three physicians and a well-qualified public health nurse on our committee. These people are in charge of the medical teaching staff and help spread the gospel to it. They, with the director of the school, appoint the physicians to do the teaching. They also have studied the Curriculum Guide and meet each term with the teaching group, including the physicians, instructors and teaching supervisors. The outlines of the various courses are discussed and revised.

One of the most valuable members of our committee is the lay woman member. She is a college graduate, has been a teacher and is able to give considerable time to our needs. Her special function is the upkeep of the nurses' home and she assists the director with the extraprofessional program for the students. She is invaluable in spreading the gospel of nursing education in the community and much of the splendid cooperation we have had from community agencies has been due to her efforts.

Teaching Preventive Nursing

The students' own health program can be made the basis for teaching the preventive elements of nursing. From the time she makes application for admission to the school the prospective student is made conscious of the fact that health is an essential factor in a useful life. She is given a physical examination and is required to remedy certain defects, such as diseased tonsils, before she is allowed to become a member of the school community. This requirement is a preventive measure against epidemics of sore throats and colds among the nurses rather than a policy whereby the hospital may be spared the expense of a tonsillectomy and the loss of student assistance.

Photograph from St. Luke's Hospital, Chicago

Lectures and notes are important parts of the training of student nurses.

The immunization program begins before admission and continues, along with periodic health examinations, after her admission to the school. Our students are tested and immunized in the clinic on regular "immunization days" so that they will realize that the program is not peculiar to a nursing community alone but is essential in a health program for any community. We also send our students out to assist on immunization day in the public schools. The student should look at the school as a small community with the promotion of health as a vital part of its existence.

Most of us have not made the best of our opportunities to use the student health program as a means of health teaching, perhaps because the direction of the program is one more thing added to the already overcrowded schedule of some member of the staff.

Our health directors are all too often no more than persons to whom students report infected fingers and stomach-aches. In our school the nursing arts instructor is also health director, which affords her an opportunity to carry out the objectives of unit 3 in "Introduction to Nursing Arts" beyond the limited time that can be given during the teaching of the course.

A social and extraprofessional program is difficult for the small school of nursing, especially when it is located in a small city where concerts and lectures are few and expensive. Many of us do not have budgets that include a social director and when instructors or supervisors undertake such a program we fall into many of the evil practices warned against in the Curriculum Guide.

The greatest problem is to find leaders who are "interested in student contacts" and "motivated by a spirit of service which will show itself in a willingness to spend time with the group and to secure additional training, if necessary, in order that the activity may be fruitful." If we can make the community feel that the school of nursing is a vital part of its educational system in preparing its youth for a life of service, we can often draw on it both for facilities and for leaders to promote special activities.

The lay woman member of our nursing school committee has played an important part in developing our extraprofessional program. It has been through her influence and contacts that we have been able to use community organizations and agencies to carry out our program. The churches in the community have been most cooperative in assisting us. They not only keep in touch with the students who belong to their particular denominations but make a point of inviting the student group as a whole to attend social gatherings and devotional meetings.

Our students have expressed an interest this year in sports and games and music besides their regular series of parties. We are fortunate enough to have a grade school building across the street from us. This building has a good gymnasium and we have been able to arrange with the city recreation department to use this gymnasium one evening a week. The city provides us with a leader and all equipment for a dollar a night.

We have a glee club for those who are interested in music. The school of music at our local university provides us with a director who often brings groups from the university to sing with our girls. These "sings," as they call them, are followed by a social hour of games, dancing and refreshments. One of our supervisors is especially interested in this type of work and acts as adviser to the group.

Last spring some of the students expressed a desire for a flower garden and our hospital gardener gave them a plot behind the nurses' home and provided them with seeds and plants. The students spaded and cared for the plot themselves under his direction. They took a great deal of pleasure in arranging bouquets from their garden for the home.

Our students participate in such community activities as the Red Cross and Community Chest drives. They undertake to make Christmas happy for some needy group; last year it was an orphanage for colored children. They find out what agency is handling the group and work in cooperation with that agency.

Much has been said about the difficulties small hospitals, especially in small communities, experience in obtaining the type of graduate nursing service they would like to have. It is said that when students go to larger hospitals for affiliations they are unwilling to return to the small community for service after graduation.

If the student nurse is made aware of definite community interest in and support of nursing education and becomes conscious of the needs of the community for her services, she will be anxious to return. This partnership between the nursing profession and the community cannot help but benefit both groups.

Hospital's Duty to Dentistry

E. M. BLUESTONE, M.D.
Director, Montefiore Hospital, New York City

A SUCCESSION of bitter experiences has taught us that health protection, though still somewhat imperfect, can oftentimes be bought with money. We agree in principle, if not in practice, that a penny-wise, pound-foolish attitude toward health is bad business in the long run. Public health, either as an abstract or as a practical concept, makes no distinctions where there are no differences and the care of the mouth, including its bony structures, has, therefore, equal significance with the care of other parts of the body. Dental service is in the general field of medicine where it belongs by right.

As a matter of self-defense, a hospital should have a well-staffed and well-equipped dental department if it is to escape criticism on the score of incompleteness. "No chain is stronger than its weakest link" and this holds good in the clinic. We have built, organized and financed an interesting dental department at Montefiore Hospital for Chronic Diseases, New York City. The department enjoys equal scientific rank and treatment with all other specialties. The opportunities for scientific investigation are perhaps greater than in most hospitals because our patients are under control for longer periods of time and our investigators are, therefore, in a position where they need not guess the remote results of treatment. In all other respects, however, the opportunities for dental service are alike.

So far as this department is concerned, our budget is balanced in relation to other clinical services. We have a self-contained department with an authoritative staff, a high degree of specialization and up-to-date facilities. Our dental staff has earned the respect of the medical board, of which the attending dentist is a member, and the philanthropic interest of the board of trustees, which appreciates the place of dental service in a modern hospital. I mention these specifically because they are vital factors in the development of a dental program.

Unfortunately for all of us, we have come upon evil times and are compelled to retrench all along the line. Retrenchment in money must, however, strike with an even hand, depriving each one of his just share. The sentiment that prevails in certain quarters about dental service being a luxury in hard times must be resisted. Available decreases, like increases, should be shared in proportion by all clinical departments. The only excuse for favoring one department over another would be the presence of special talent in that department that is prepared to exploit original ideas which are deserving of encouragement and which have a fair prospect of achieving results.

The first use to which dental funds in the community should be put is to build a stronger appreciation for dental service everywhere, including periods of illness in the hospital and including the nonurgent interludes of dental pathology. The recently arrived public relations authority should be consulted on this point. Education of the public to the practical value of dental expenditure has a direct bearing on dentistry in hospitals. It creates a reasonable demand for service and this, in turn, stimulates giving and serving. It helps to smooth the way of the dental staff, as well as that of the hospital administrator.

In some instances, a number of progressive steps may be taken in the dental field without the expenditure of an additional penny. We are honor bound to improve what we have before undertaking greater expenditures. Giving the chief of the dental department a place on the medical board of the hospital costs no money and may, indeed, save some. This is but one example.

Preventive dentistry is an easier field for quick accomplishment than is preventive medicine generally. The dentist has an advantage over the physician in that he deals with more tangible things. The oral structures are clearly outlined and show up even better with a little assistance from physical agents, such as the lens and the x-ray machine. The psychic element is reduced to a minimum, for a toothache is a toothache. You can neither talk it into a patient nor talk it out of him. The opportunities for the application of mechanical skill are greater. The approach is more direct and often more successful—so much so that the punishment for dental neglect, thanks to our inventive friends in the restorative branch of the dental profession, is not proportionate to the damage, except in a financial way.

No matter how good the times may be, the most unreliable contributor to the program of dental advancement is the patient himself, unless he is blessed with sufficient funds to indulge himself. He will seek relief from a toothache but may neglect the more insidious pathologic changes to which he is heir.

"If I only had the money" is a common lament of administrators. Doctor Bluestone tells what he would do for the dental department if he had the money. He also points out ways in which this stepchild of the hospital can be strengthened and improved, as it deserves to be, without an unduly large expenditure of cash

From an address to Greater New York Conference of Hospital Dental Services, 1940.

In any case we must find other sources of financial support. In default of an adequate supply of philanthropic funds, we are being thrown more and more on the bounty of the government (meaning the taxpayer) for greater financial support. Whatever the source of financial supply, however, it must be increased and should be sufficient to cover dental service from infancy to old age, wherever the individual can be reached, and not alone during periods of emergency which compel immediate attention because a nerve has been irritated.

A sufficient number of intelligent, well-trained and adequately paid oral hygienists, working under constant dental supervision, should be available in hospitals to prevent or to limit dental damage. Only one precaution need be observed—we must not overdo it. There is still some controversy about the relative merits of certain forms of dental prophylaxis and special care should be taken to avoid the overemphasis of some forms of dental hygiene that have restricted scientific application.

The dental department is entitled to its share of space, commensurate with the need of other specialties. It should be near the operating rooms; otherwise, its location is relatively unimportant, so long as patients can be handled at the bedside with the use of portable facilities. It should be a self-contained unit as independent as possible of the other diagnostic and therapeutic departments of the hospital, such as the pharmacy, the general laboratory, the operating rooms and the general x-ray laboratory.

"Elbow Room" Is Necessary

There should be lots of elbow room for both patient and dentist. An integrated department within this space calls for (1) specialized services, (2) a sufficient number of well-equipped chairs, (3) facilities for sterilization, (4) facilities for the demonstration of patients, (5) a laboratory for oral pathology and bacteriology, (6) an x-ray laboratory with adjacent developing room and (7) a mechanical laboratory. All of these may be built around a central waiting room with a nook for the departmental clerk and her record system. In some instances the dental department may be dependent on other departments, such as radiotherapy, clinical photography (microphotography, too) and physical therapy, generally.

Plenty of natural and artificial light must be provided, in accordance with the requirements of the operator. Good lamps cost good money. A cheerful color scheme that is restful to the eyes of the patient and easy on the operator is helpful and inexpensive. Air conditioning and soundproofing are desirable when money is available. We need not go to extremes in planning and must judge expenditures by the expected return.

Aseptic conditions of operation, that is, a completely sanitary unit, are essential. With all this go intelligent nursing and clerical assistance. In a dental department such as this, a patient arriving for consultation gets the advantage of group dental practice on the spot in a self-contained unit that saves unnecessary steps for everyone concerned; moreover, his record is kept in such a manner that it can be considered in a series for scientific study.

Equipment Should Be Modern

Mechanical equipment, with which the dentist's work is associated more than that of the physician, is important. Skilled help, dental and otherwise, requires good equipment to make the ideal combination, and good facilities include a reasonable expenditure for experimental equipment. Whatever money does not buy is paid for out of the nerves of the patient and, to a lesser extent, out of the nerves of the dental staff. We find that comfort, too, is purchasable.

Equipment must be up to date, complete and in constant repair. Allowance for depreciation must be included in this item in order to guarantee replacements on short notice. To prevent waste of money, a duty that goes with the management of any trust fund, equipment must be safeguarded against mechanical defects, vandalism and theft.

Skill and clinical imagination are sometimes purchasable. Naturally enough, private practice comes first in the life of the professional man who must make a living. The full-time or part-time salary principle is in its infancy in the dental profession. The result is that the hospital gets the leavings from workers who are required to serve on a voluntary basis in return for practical experience and prestige.

Salaries should be increased to the point where the patients will receive the maximum benefits from dental service in hospitals. We have found again and again that small funds and relatively small inducements produce large returns. Dental scientists with new and promising ideas, either at the bedside or in the laboratory, require equal financial encouragement with medical scientists. Fellowships must be made available on equal terms.

Developing Special Talents

Next to the financial subsidy to workers comes the precious opportunity of developing one's special talents. This is payment of a kind. Stimulating material in accordance with the selective interests of the dentist and the opportunity to work out new and possibly better ideas under adequate auspices are important. This leads us to the laboratory, to which all men who plan for the future must go.

In a practical sense, the dental department in a hospital supplements the work of the dental school. It is a postgraduate dental school, in fact, and as such must establish and maintain the highest academic standards. Interns here enjoy a multiple clinical apprenticeship and the department staff must, therefore, be approachable and possess the power of cooperating, teaching and discovering improvements.

Dental clinicians are men of science. They learn quickly that no two cases are exactly alike. They must, therefore, learn fundamental principles and then develop the power to analyze and adjust them to changing clinical circumstances. The laboratory thus becomes as necessary to the man of ideas as food is to his stomach, for, without it, he becomes intellectually starved.

We must put healthy teeth into the fight for complete and universal dental service at costs that every individual and community can afford. Some form of group insurance would help to bring this about. This is not as expensive as it would be if we had to wait until the dental situation became so bad that we could do nothing about it without even greater expense.

8 Modernization Projects

WITH A FOREWORD ON REMODELING BY WILLIAM A. RILEY

Points to Consider—

Before Building Program Is Begun

WILLIAM A. RILEY

Architect, Stevens, Curtin, Mason and Riley, Boston

THE development of a logical and progressive expansion program, with the necessary replacement of existing services, requires a hospital survey based on much research and study. The purposes of such a survey are as follows:

1. To determine the need for increased facilities for all departments of the hospital.
2. To determine the allocation of space in the existing buildings for the best functioning of the various departments.
3. To present by tables and charts the past and present history of each department.
4. To recommend the most practical location for any new buildings that may be needed for immediate and future requirements.
5. To estimate the potential income and operating costs for proposed and existing beds.
6. To determine the approximate costs of the immediate needs, arranged on a step program basis in order to allow the completion of each unit as funds become available.
7. To develop sketch plans illustrating the complete architectural recommendations.

All of the replacement and expansion studies should be based upon the results of conferences with appropriate committees, members of the staff and the administrator to the end that the opinions from these sources may contribute to the best solution.

Proper Ratio of Beds

Care must be exercised to avoid planning for too many beds. The proper ratio of beds per thousand in all hospitals in the district will depend upon many factors. A decrease in hospital days per patient and an increase in preventive work will tend to reduce the number of beds required, while a gain in diagnostic service and greater enrollment in hospital service plans will tend to increase them. If service for tuberculous, psychiatric, convalescent or chronic disease patients is offered, this will also affect the bed ratio.

It may also be necessary to consider the social and financial circumstances of the community and the physicians and surgeons who refer the patients to the hospital. Each hospital should make its plans with due consideration for the needs of the entire community and the part that other hospitals in the vicinity may properly be expected to play.

In many instances, proper apportionment of beds has not been given sufficient attention. Many hospitals today have too few semiprivate accommodations and too many ward beds. The average voluntary general hospital cannot support too many ward beds. Under certain circumstances a ward patient may be cared for in a private or semiprivate room, but a private patient will strongly object to being placed in a ward bed.

Another phase of the survey should consider each of the different divisions. The medical, surgical, pediatric, obstetrical, isolation and other departments should definitely be planned for adequate expansion and segregation. The maternity department must be large enough to allow for peak loads and fluctuating demands. Because this type of hospitalization is anticipated and because the patient has usually made some provision for meeting expenses, the number of private and semiprivate rooms in the obstetrical department may be higher than in the other departments.

Past and present histories of all departments arranged in table and chart form for easy reference will help to clarify expansion problems. If these records cover a period of at least ten years, a chart may be made that will indicate present conditions and help to estimate future needs.

The survey should also contain history charts and tables of the following subjects: (1) residence of patients by years; (2) hospital district showing territory served; (3) existing schedule of beds by type of accommodation; (4) existing schedule of beds by departments; (5) number of patient days; (6) patients admitted to all departments; (7) operations performed; (8) number of births; (9) number of visits to outpatient, x-ray and emergency departments; (10) existing per capita costs; (11) daily averages, and (12) proposed schedule of beds.

In the next part of the survey the problem of location of added facilities for proper light and air should be considered. Additional accommodations for patients usually mean modifying and enlarging the nurses' residence and the service buildings. Many hospital administrators and trustees have never visualized the future needs of their hospitals and, hence, land for extensions may have to be acquired at excessive cost.

Plan for Future Needs

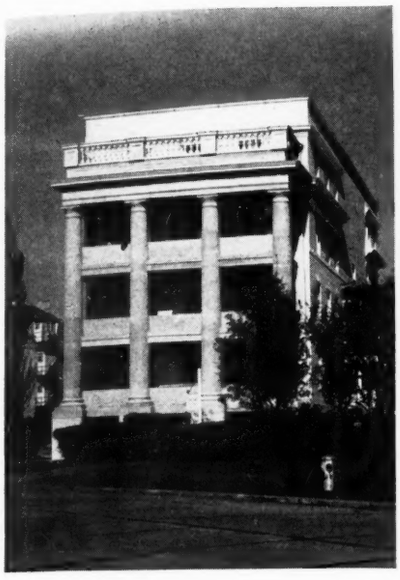
A program that considers the needs of the hospital for a few years only is not feasible. Usually, a large construction program requires favorable response and financial cooperation from the community; too many requests for funds in too short a time will not be received favorably. The survey may prove the feasibility of scrapping old buildings that are fire traps or that have excessively high ceilings and insufficient facilities.

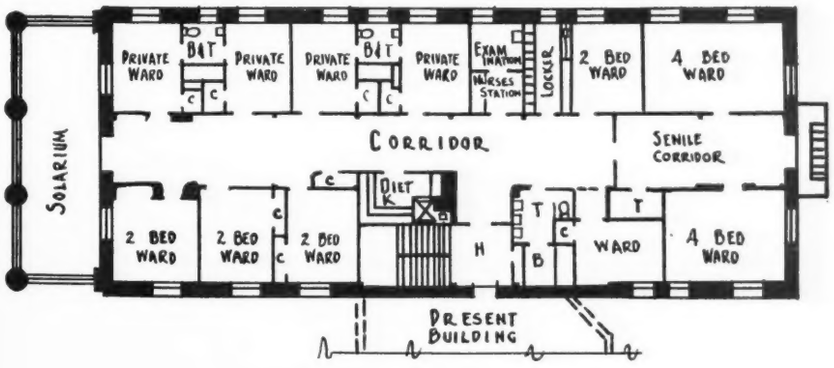
Any comprehensive survey will recognize the value of a proper balance between potential income and operating costs. Expansion and modernization programs should be planned so that the total sum can be subdivided in order to permit the completion of the entire program in proportion to the funds available. This arrangement will prove valuable, especially when insufficient funds prohibit carrying out the entire program at one time. It will be wise to estimate the cost of all proposed work in a breakdown form that shows the costs for each of the various units and stages of the program. These prices should include all architectural and engineering fees.

NEUROPSYCHIATRIC WING, ST. LUKE'S HOSPITAL, SPOKANE

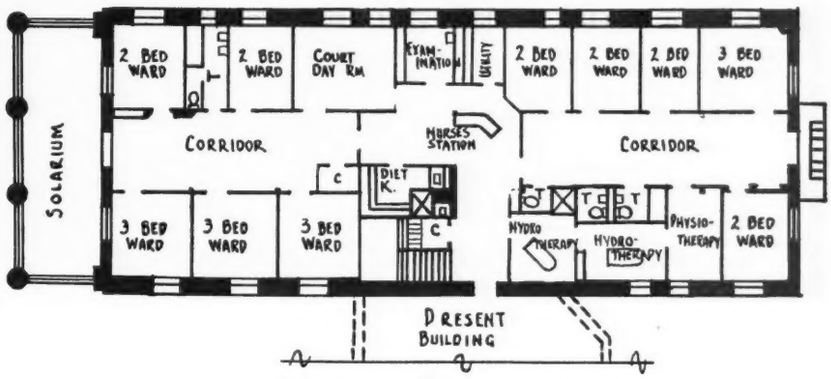
RIGG and VANTYNE ARCHITECTS

Administrator: Gordon W. Gilbert

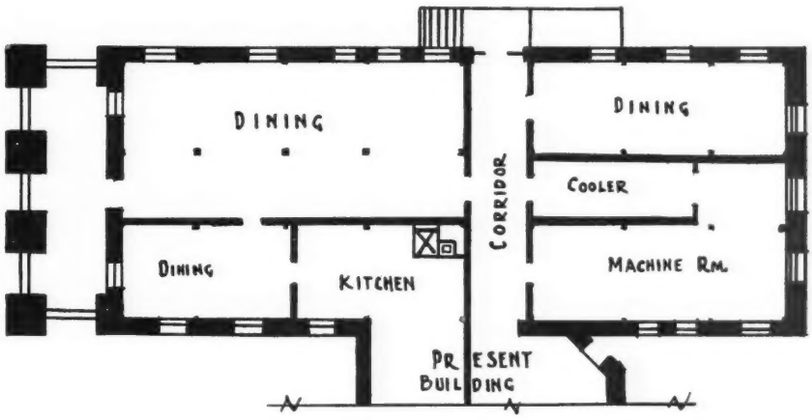




SECOND, THIRD & FOURTH FLOOR PLAN



FIRST FLOOR PLAN



SHADLE MEMORIAL ...
RIGG & VANTYNE ARCHITECTS
SCALE
0 5 10 15 20

Plans and exterior view of the Shadle Wing of St. Luke's Hospital. The ground floor plan is shown at the bottom. Numerous safety features are incorporated in the building to safeguard both patients and personnel.

CONSTRUCTION DETAILS

GENERAL DATA: Four story, 80 bed addition to general hospital, designed for care of nervous and mental cases. Fourth floor to be finished at a later date.

CONSTRUCTION: Reenforced concrete frame with reenforced concrete slabs. Exterior walls, brick; interior partitions, hollow tile. Exterior doors, hollow metal; doors separating ward units, metal. Windows, all steel, special detention type, glazed with translucent glass except for clear plate ventilating panels. Stair treads, metal. Doors and cupboards, bronze detention hardware.

FLOORING: Marbleized linoleum, 9 by 9 inch blocks, laid on concrete subfloor with 4 inch coved linoleum base, metal caps and corners. All water sections, random pattern, nonskid tile.

WALLS: Corridors, main rooms and wards, hollow tile plaster. Water sections, 4 by 4 inch ceramic tile.

CEILINGS: Wards, corridors and nurses' stations, acoustical tile.

HEATING: Low pressure steam with separate ventilating fans for each floor. Separate ventilating fans for all toilets and baths. Radiators, recessed, cast iron.

LIGHTING: Corridors and rooms, flush lights. All rooms equipped with three volume light control. Light switches located in corridors and at nurses' stations.

DUMB-WAITERS: Automatic, self-leveling electric; floor-to-floor call push button.

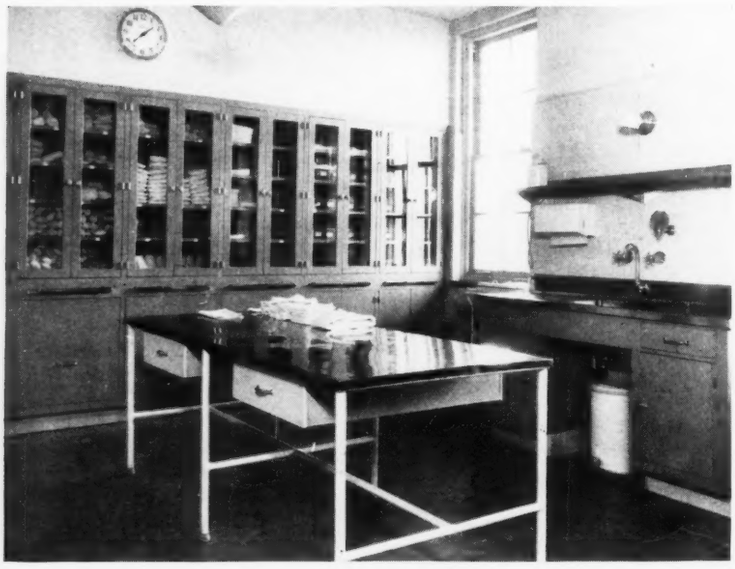
INTERCOMMUNICATING SYSTEM: Complete system throughout wing connected with central building. Master switches located at all nurses' stations and serving kitchen in Shadle Wing; also in administrator's office and at switchboard in central building. Recessed speakers in all patients' rooms and wards.

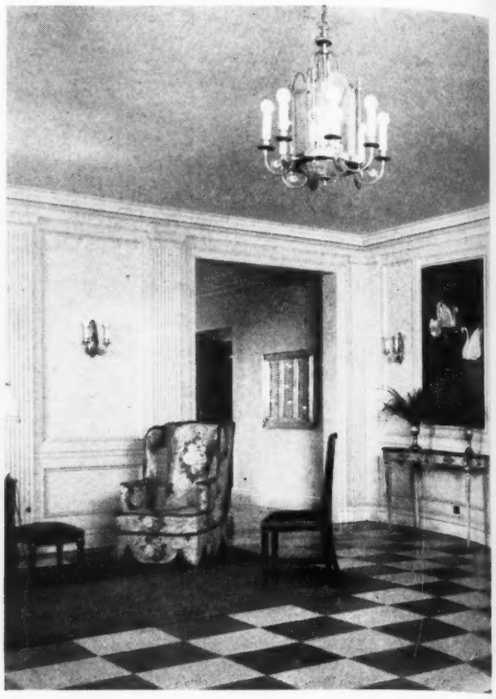
EMERGENCY CALL SYSTEM: Lamp and buzzer annunciator with indicators at all nurses' stations. Buttons beside doors leading to wards for acutely disturbed and senile patients.

COSTS: Total cost, $100,000. Volume, 265,000 cubic feet. Cost per cubic foot, 38 cents.

FINANCING: Bequest from Mr. and Mrs. Eugene A. Shadle, Spokane.

PAVILION, MUHLENBERG HOSPITAL, PLAINFIELD, N. J.





Above: Corner of the nurses' workroom showing the built-in metal cabinets around the walls, stainless steel topped work table and sink. Right: View of the attractive entrance lobby of the pavilion.

Superintendent: John R. Howard Jr.

OUTLINE OF CONSTRUCTION DETAILS

GENERAL DATA: New pavilion connected with existing administration building to provide new administrative offices, operating department, living quarters for eight interns, machine rooms, storerooms, locker and toilet rooms.

CONSTRUCTION: Fireproof throughout. Steel frame. Exterior walls, brick with terra cotta back-up tile. Floors, reenforced cinder concrete slabs. Portico and trim, Indiana limestone. Window frames and sash, wood (hollow metal where exposed to adjoining buildings). Interior partitions, hollow tile and gypsum blocks. Door frames, metal. Doors, wood; flush surface in second story; paneled elsewhere.

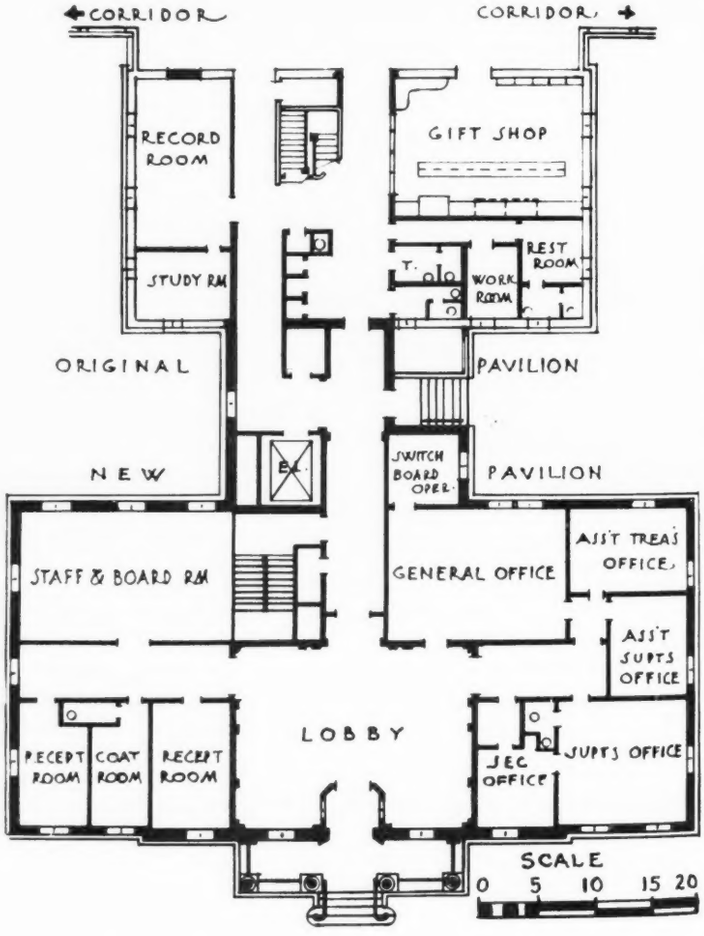
FLOORING: Entrance vestibule, marble floor and base. Lobby and first floor corridors, terrazzo and marble base. Operating rooms, toilets and housemaids' closets, colored ceramic tile. Reception rooms, staff and board room, rubber tile. Offices, corridors, rooms, linoleum.

WALLS: Generally, gypsum plaster. Corridors, toilet rooms, housemaids' closets and all rooms in surgical department, colored tile wainscot. Staff and board room, wood panels to ceiling.

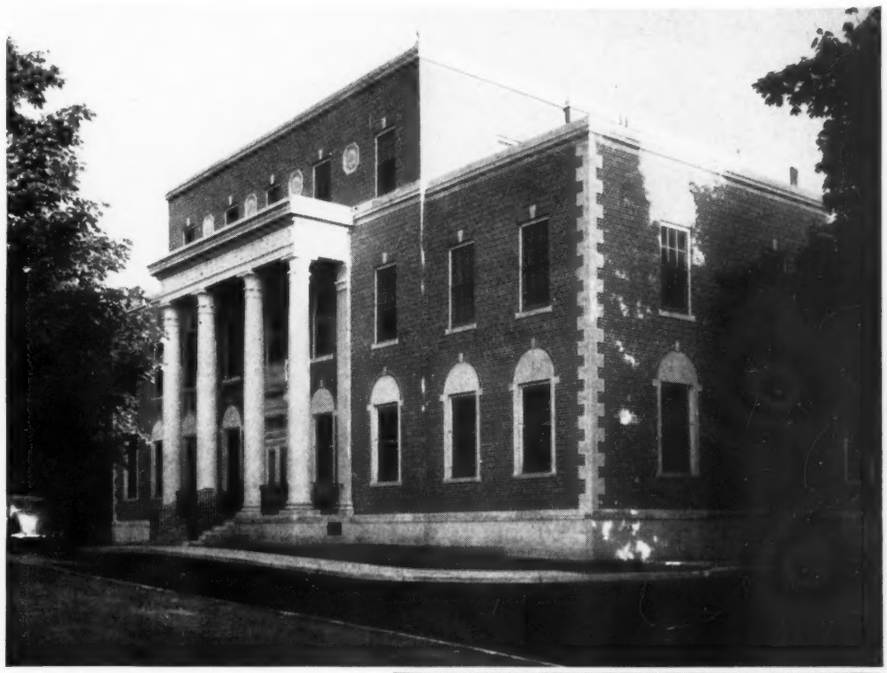
CEILINGS: Generally, gypsum plaster. Telephone room, general and secretary's offices and second floor corridor, acoustical tile.

HEATING: Low pressure steam; medium pressure steam to sterilizers from central boiler plant; exposed radiators in third story; convectors elsewhere.

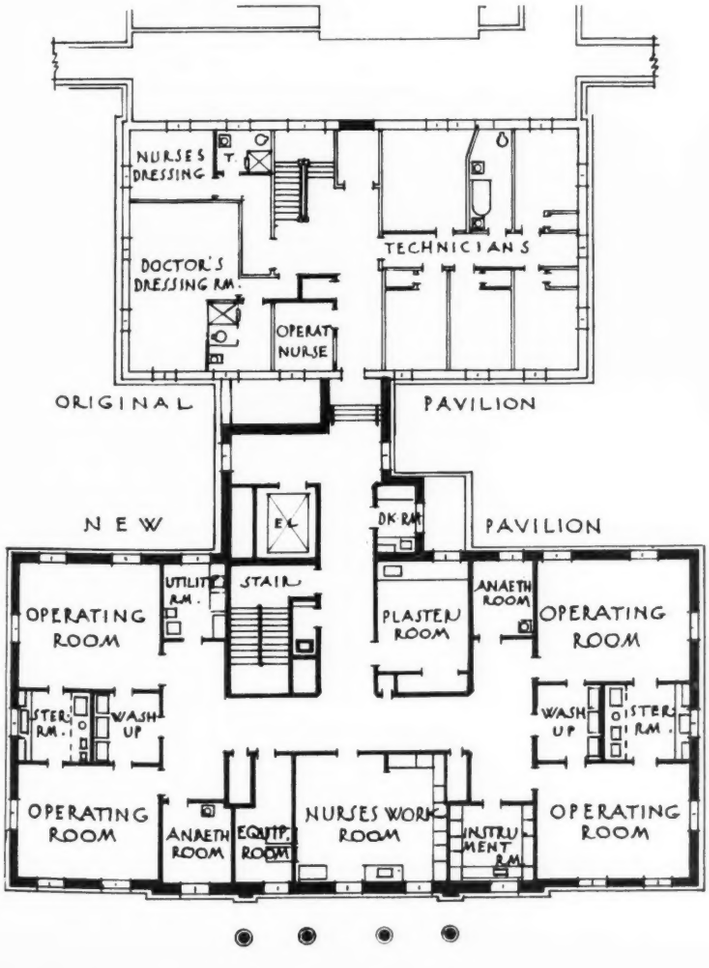
VENTILATION: Filtered, washed and humidified air to operating, anesthesia and plaster rooms, together with mechanical exhaust; also a supply and exhaust system for staff and board room. Exhaust system from toilets and various other rooms.



Above: Plan of the first floor, which is devoted to administrative offices, reception rooms and staff and board room. A gift shop now occupies the site of these offices in the older building.



Above: Entrance to the administration building. Right: The gift shop in the old pavilion. Below: Second floor plan. Operating rooms equipped with darkening shades and suction devices.



LIGHTING: Operating room, special fixtures. Elsewhere, direct lighting. Gas driven emergency lighting unit.

CALL SYSTEM: Lamp emergency system on second floor. Doctors' silent paging system. Doctors' electrical "in-and-out" system on second floor.

ELEVATORS: Electric, self-leveling, semidual control. Speed, 250 feet per minute. Car and shaft doors, automatically controlled.

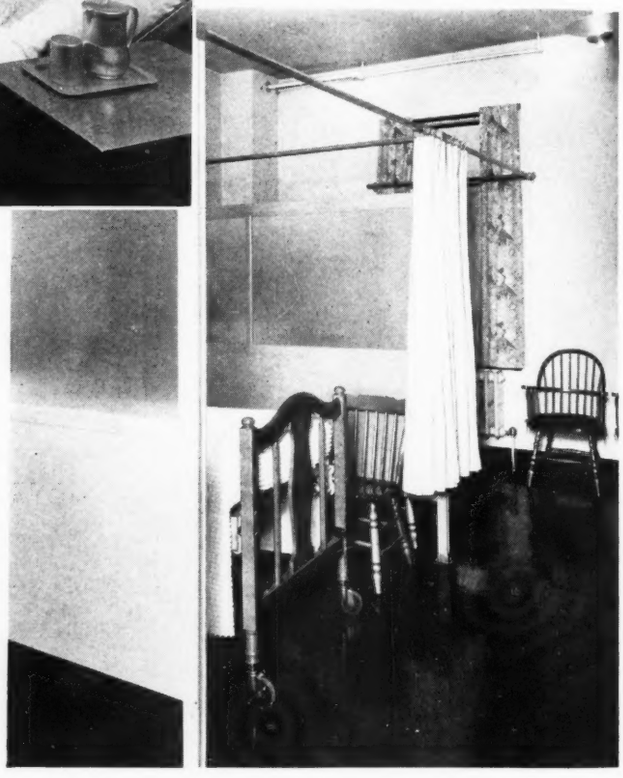
COSTS: $250,000, including $18,000 for alterations in original building.

FINANCING: Memorial building financed by two bequests.

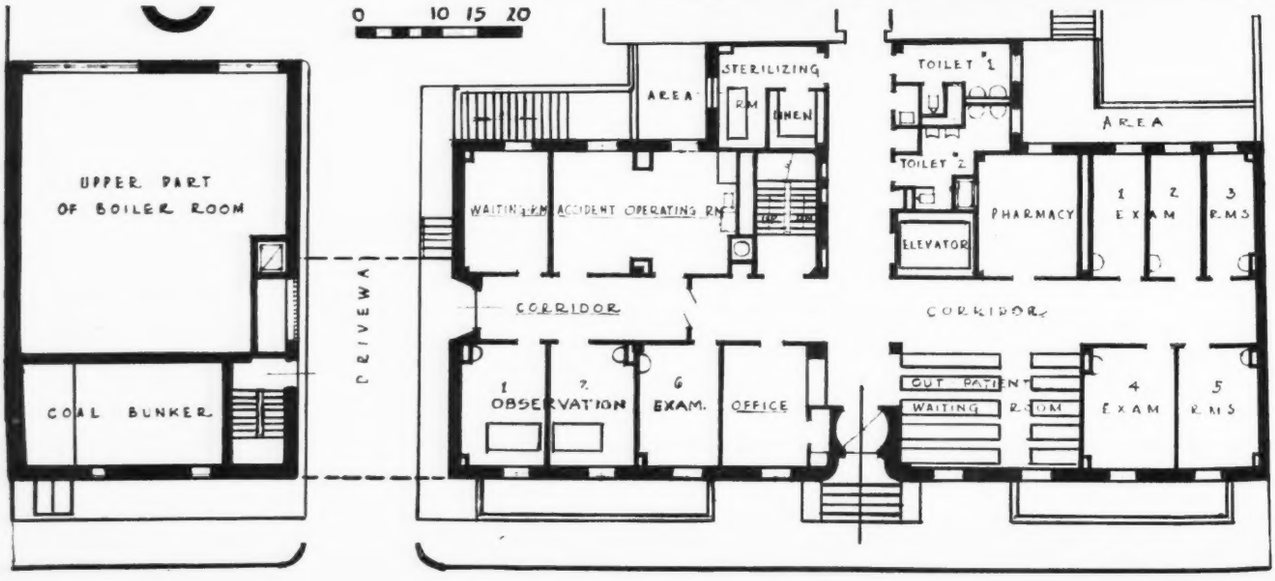
WING, SOUTH BALTIMORE GENERAL HOSPITAL, BALTIMORE

Director: E. Reid Caddy

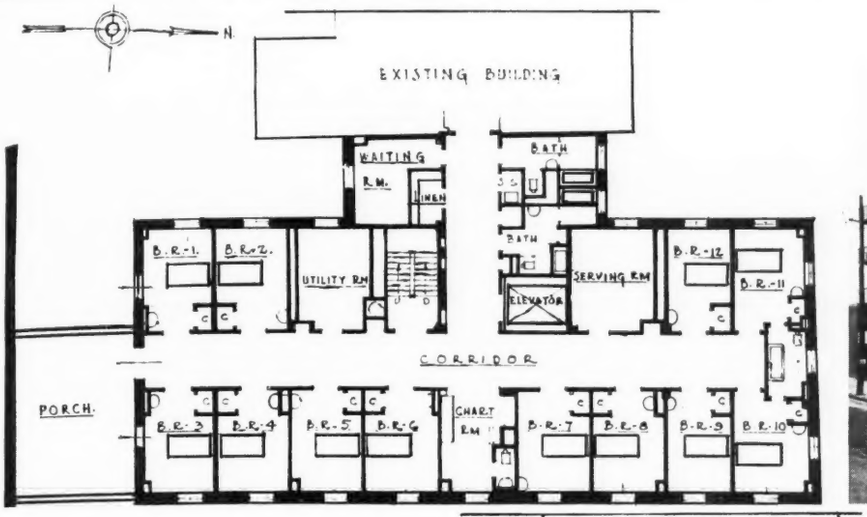
Opposite Page: Plan of second and fourth floors. Twelve rooms are located on each floor; every room has a clothes closet and lavatory. Two of the rooms have an adjoining bath that may be allocated to either room or used semiprivately. Lighting is indirect and a night light is built into the ceiling fixture.

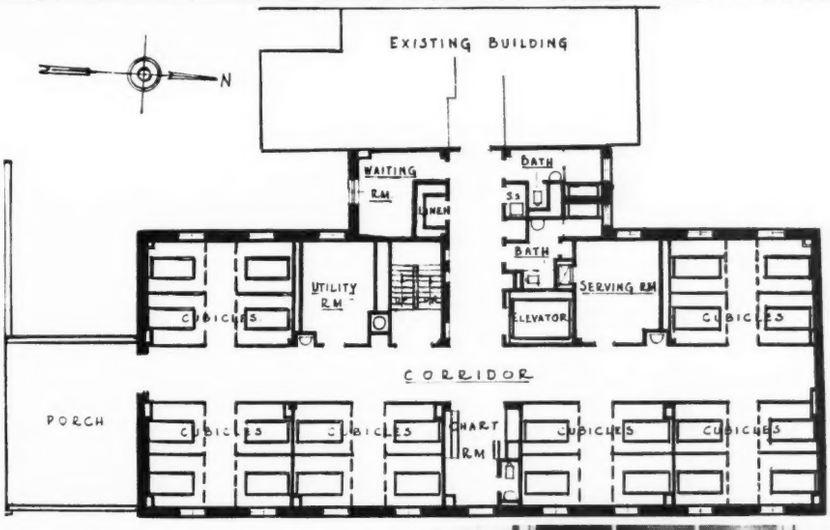


Above: A patient is made comfortable in one of the private rooms. Furniture in these rooms is walnut finished wood of classical modern design. Right: One of the 24 glass and steel enclosed partitions. Each unit is provided with a clothes locker, bedside cabinet, overbed table and two chairs. Below: The first floor accommodates the out-patient department, six examining rooms, waiting rooms, emergency suite and the pharmacy department. The emergency suite comprises an operating room with two tables and two observation rooms with two beds in each. An anesthesia stretcher is kept in the suite for use as an additional operating table. A cast dryer is also kept in this unit. The basement of the new wing, which is not shown, houses a necropsy room, cooling box, pathology storage room and locker room, in addition to the kitchens, bake shop, preparation room, cafeteria and serving room for employes.



PALMER and LAMDIN, ARCHITECTS; HERBERT G. JORY, ASSOCIATE





Right: The third floor houses 24 cubicles in groups of four. The furniture in the cubicles is of early American design, with maple finish. The walls of the wards are painted in various cheerful pastel tints.

Above: Exterior view of the new wing. The addition forms one side of an H-shaped unit which is planned to permit of future expansion. Below: A little patient is treated at the clinic for sick babies.

OUTLINE OF CONSTRUCTION DETAILS

GENERAL DATA: New wing providing 50 additional adult beds.

CONSTRUCTION: Fireproof throughout. Exterior, brick. Interior, gypsum block, terra cotta tile and glazed brick.

FLOORING: Emergency suite, terrazzo. Kitchens and serving room, red quarry tile. Private rooms, corridors and cubicles, asphalt tile.

WALLS: Baths, toilets and emergency suite, tile wainscot. Kitchen, ceramic glazed structural block.

CEILINGS: Acoustical tile in serving rooms and utility room.

HEATING: Vacuum return low pressure. One 175 h.p. stoker-fired water tube boiler; one 125 h.p. stoker-fired fire tube boiler.

LIGHTING: Indirect, except in out-patient department. Night light in ceiling fixtures.

ELEVATOR: Automatic, collective control; automatic doors.

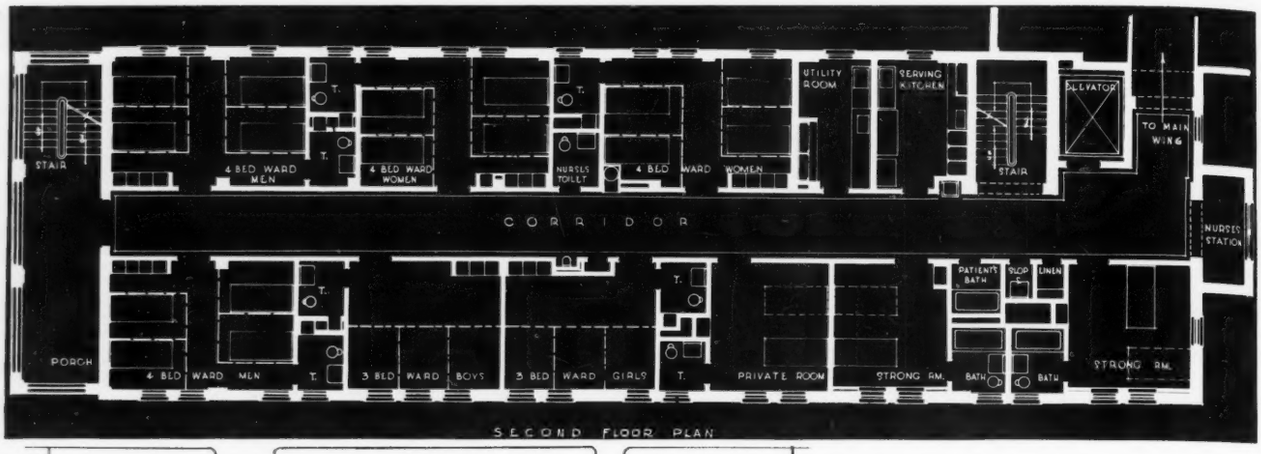
DUMB-WAITER: Electric; capacity, 300 pounds.

CALL SYSTEM: Push button, lamp annunciator nurses' call system. Loud-speaker doctors' paging system.

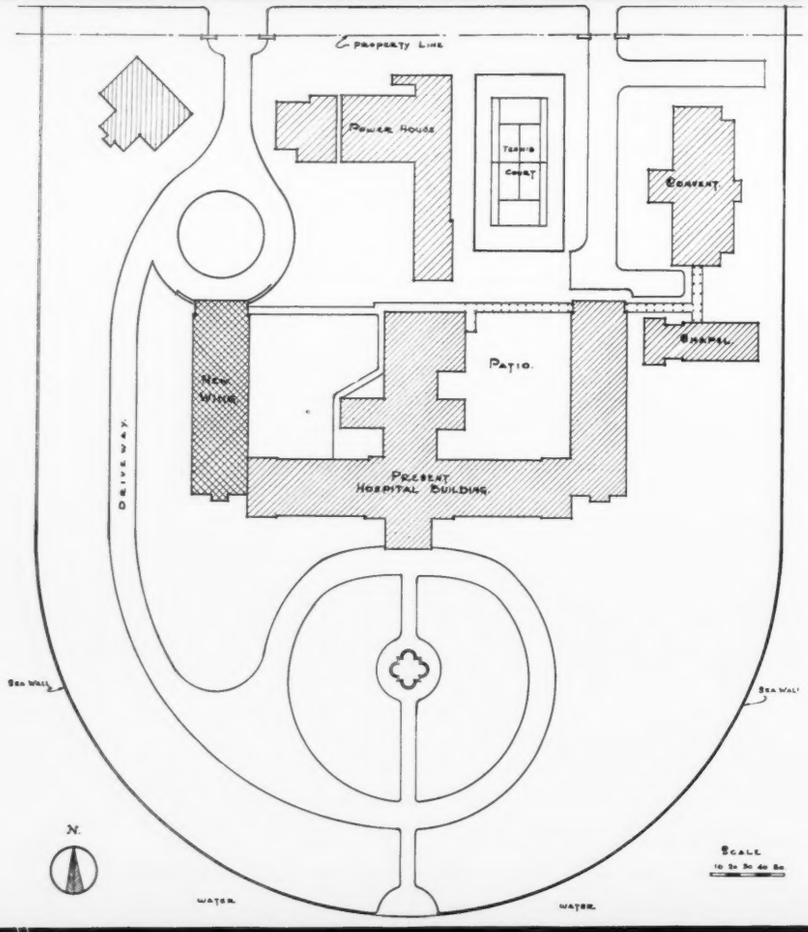
CUBICLES: Built-in, hollow metal with frosted glass.

COSTS: Building and equipment, $325,000. Volume, 380,000 cubic feet.

SURGICAL WING, ST. FRANCIS HOSPITAL, MIAMI BEACH, FLA.

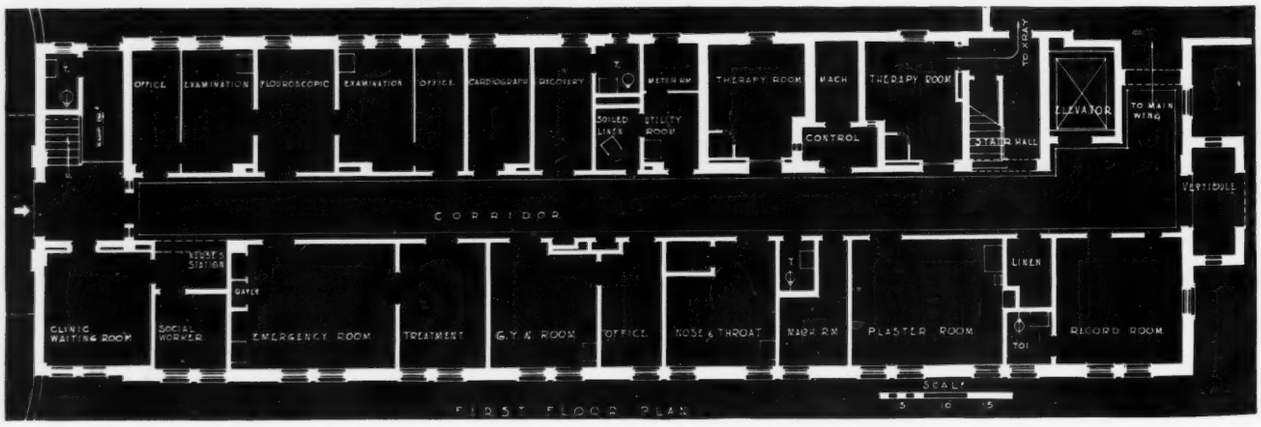


SECOND FLOOR PLAN



Superintendent: Mother M. Damian

Bottom: The first floor houses examining and treatment rooms, record rooms and two deep therapy x-ray rooms. The remainder of the x-ray department is in the old part of the hospital. Center: Plot plan of the hospital showing the addition of the new wing. The grounds of the hospital are surrounded on three sides by a sea wall. Top: Accommodations on the second floor consist principally of 3 and 4 bed wards. A nurses' station at the end of the corridor commands the whole floor. Opposite Page: Rooms on the third floor are for private patients. All of them are large enough to accommodate two beds if the need arises. The surgery floor comprises two major and one minor operating room, an anesthesia room, utility and work rooms, pathology laboratory, doctors' locker room and lounge, patients' recovery room.



FIRST FLOOR PLAN

CONSTRUCTION DETAILS

GENERAL DATA: New wing to replace old surgical section, containing clinic, emergency rooms, addition to x-ray department and 36 beds, plus 14 emergency beds.

CONSTRUCTION: Fireproof throughout. Exterior, stucco applied to concrete block. Reenforced concrete frame. Floors, pan joist construction. Exterior walls, concrete block. Interior partitions, clay tile. Canopy, reenforced concrete with white metal fascia. Windows, double hung wood with full copper screens.

FLOORING: Baths and toilets, tile. All other floors and bases, terrazzo. Operating room floors, equipped with grounded grilles.

WALLS: Operating and sterilizing rooms, ceramic glazed tile. Baths, toilets, surgical corridor, surgical lobby and clinic waiting room, tile wainscots. Doctors' lounge, wood wainscots.

CEILINGS: Corridors, nurses' station, girls' and boys' wards, children's isolation room, emergency and treatment rooms, utility room, doctors' lounge and serving kitchen, acoustically treated.

HEATING: Subatmospheric steam with additional high pressure boiler for sterilizers. Concealed radiators. Oil-fired boilers.

AIR CONDITIONING: Operating rooms, nurses' workroom and doctors' lounge, individually controlled units.

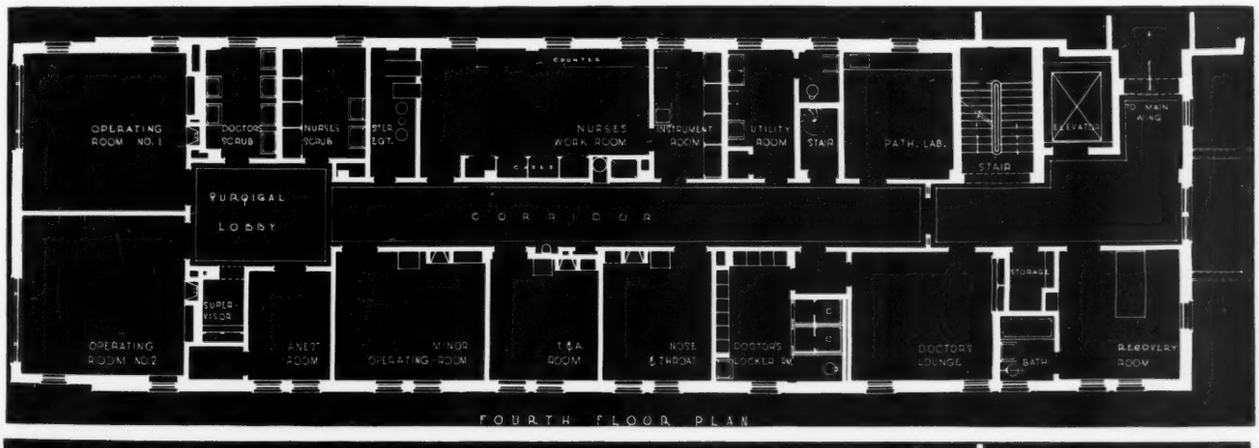
The new surgical section of St. Francis Hospital, Miami Beach, Fla.

LIGHTING: Corridors, louver lights. Rooms and wards, night lights and indirect wall brackets.

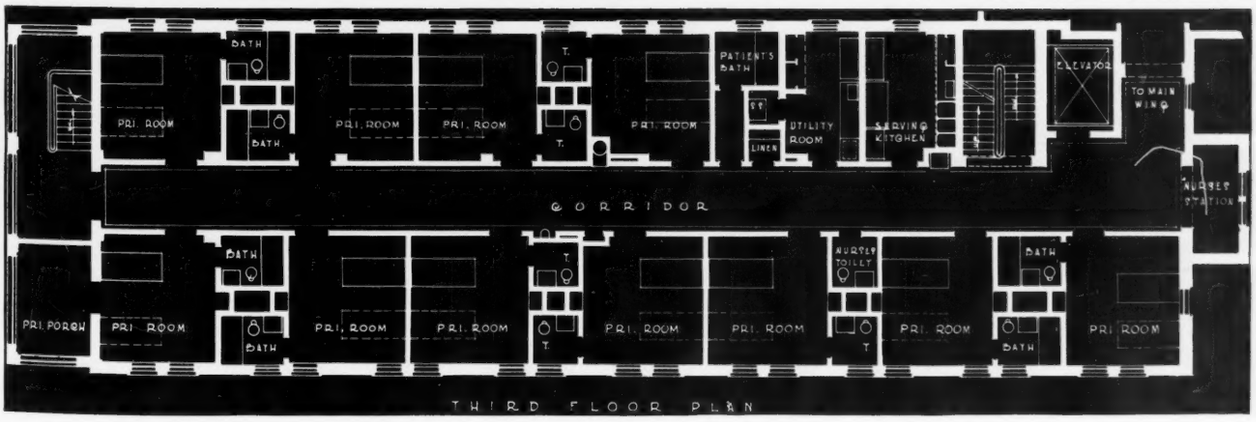
ELEVATOR: Automatic, self-leveling, collective control; double doors, motor operated; sensitive strip on doors.

X-RAY: Complete diagnostic and therapeutic equipment. Walls, floors and ceilings of deep therapy rooms, 15 inches thick in one, 8 inches in the other. Doors, lead covered and motor operated.

COSTS: Building, $160,000, exclusive of architect's fee, bond and equipment. Volume, 256,250 cubic feet. Cost per cubic foot, 62.5 cents. Cost per bed, $4444 for 36 beds; $3200 for 50 beds.



FOURTH FLOOR PLAN



THIRD FLOOR PLAN

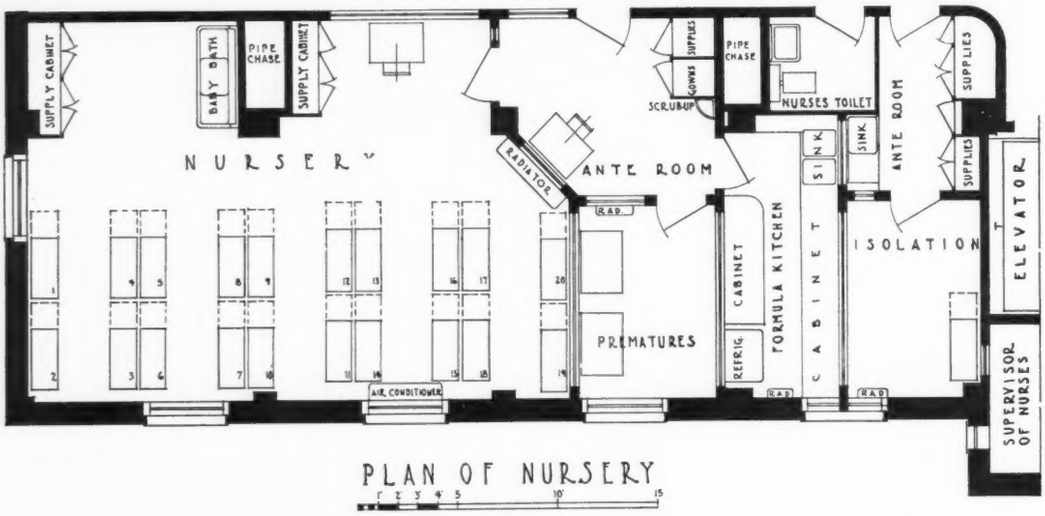
Superintendent: H. G. Hatch

CONSTRUCTION DETAILS

GENERAL DATA: New four story wing and remodeled existing building. New wing provides surgical and obstetric departments, nursery, food service department and private rooms. Normal bed capacity increased from 54 to 130, with an emergency capacity of 156 beds.

CONSTRUCTION: Concrete frame and slabs. Exterior, brick. Partitions, clay tile. Windows, double hung wood sash, with extra high bottom rail to permit ventilation at meeting rail; window stools, marble. Doors, heavy solid slab construction. Door frames and trim, metal. Bases in operating room, coved terrazzo flush with face of wall.

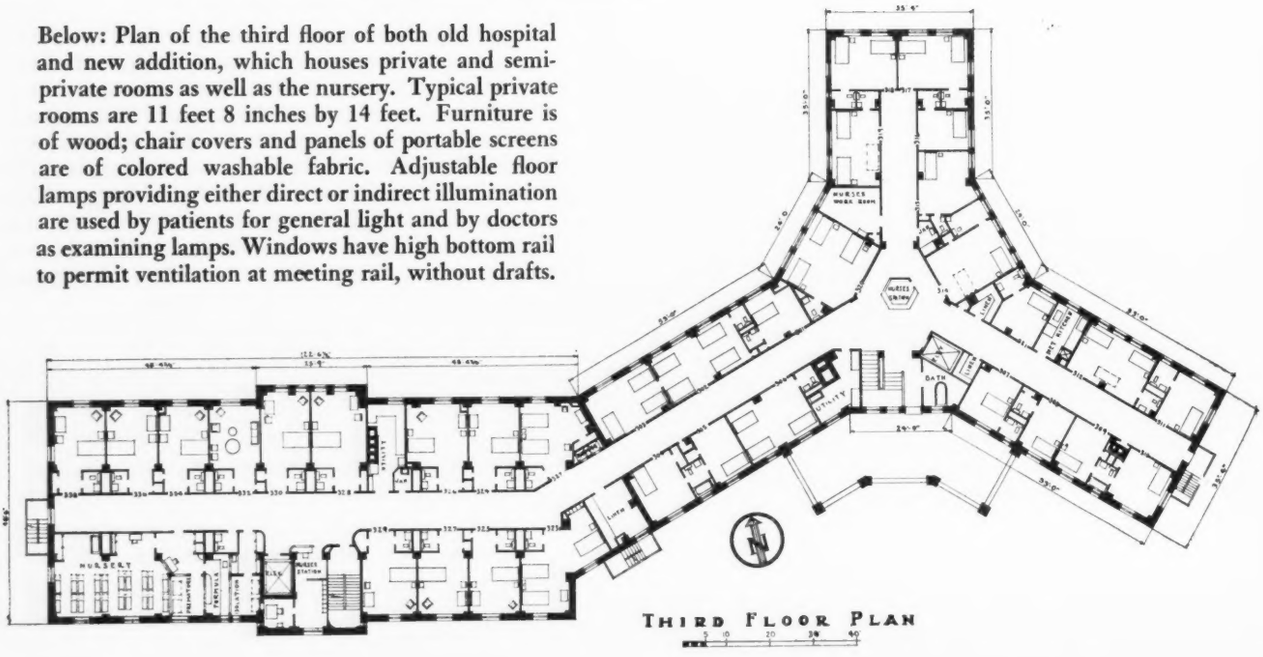
FLOORING: Private rooms and nursery, terrazzo. Operating room, terrazzo with 6 by 6 inch brass grilles grounded at two corners. Kitchen, quarry tile. Corridors, rubber tile except in surgical section.



PLAN OF NURSERY

Above: Exterior of Northwest Texas Hospital. Unit in foreground is the new four story addition. Left: A "close-up" plan of the nursery. An isolation room and room for premature infants are provided. Ceilings have been acoustically treated.

Below: Plan of the third floor of both old hospital and new addition, which houses private and semi-private rooms as well as the nursery. Typical private rooms are 11 feet 8 inches by 14 feet. Furniture is of wood; chair covers and panels of portable screens are of colored washable fabric. Adjustable floor lamps providing either direct or indirect illumination are used by patients for general light and by doctors as examining lamps. Windows have high bottom rail to permit ventilation at meeting rail, without drafts.



THIRD FLOOR PLAN

CONSTRUCTION DETAILS, Cont.

WALLS: Operating room, glazed colored tile to height of 5½ feet. Kitchen, enameled plaster with red quarry tile wainscot.

CEILINGS: Acoustical tile in corridors, delivery rooms and nursery.

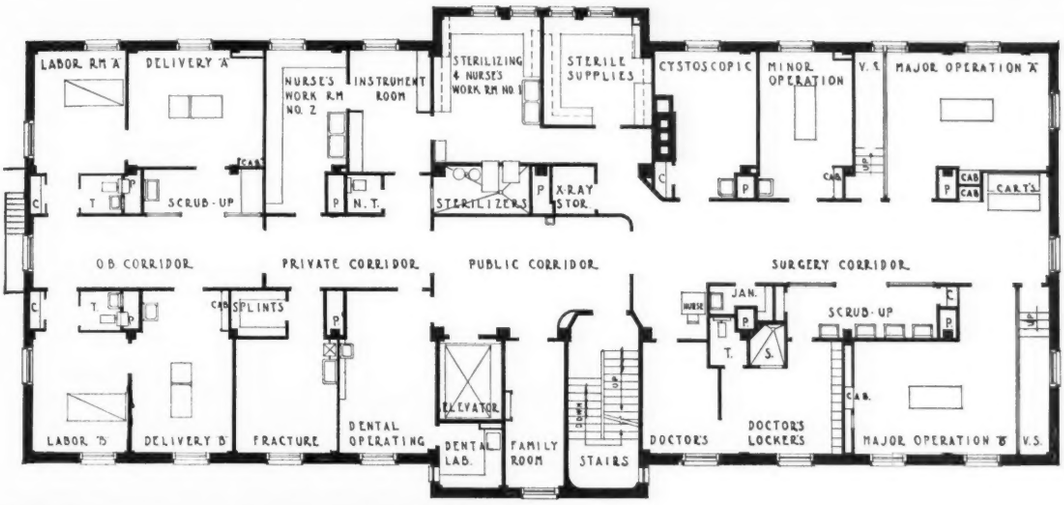
HEATING: Low pressure steam vacuum pumps. Wall-hung convection heaters.

AIR CONDITIONING: Portable unit in nursery.

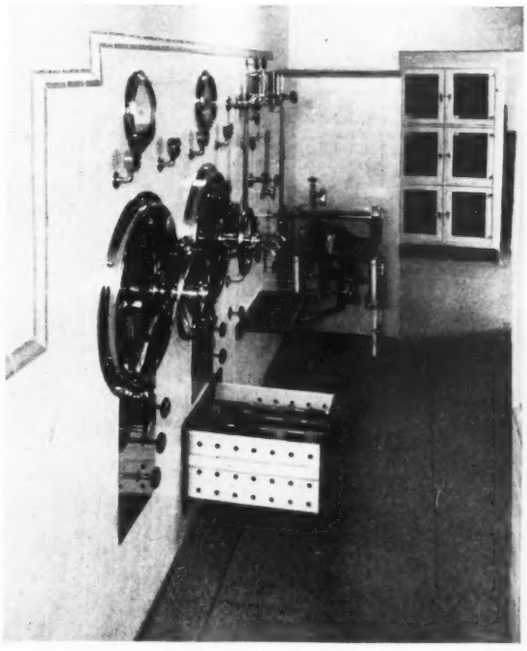
LIGHTING: Private rooms, floor lamps and recessed louvered night light.

ELEVATORS: Automatic, self-leveling, push button control.

COSTS: Total expenditure for new wing, $310,000. Volume, 327,380 cubic feet. Cost per cubic foot, 61 cents. Remodeling of old wing, $15,000.

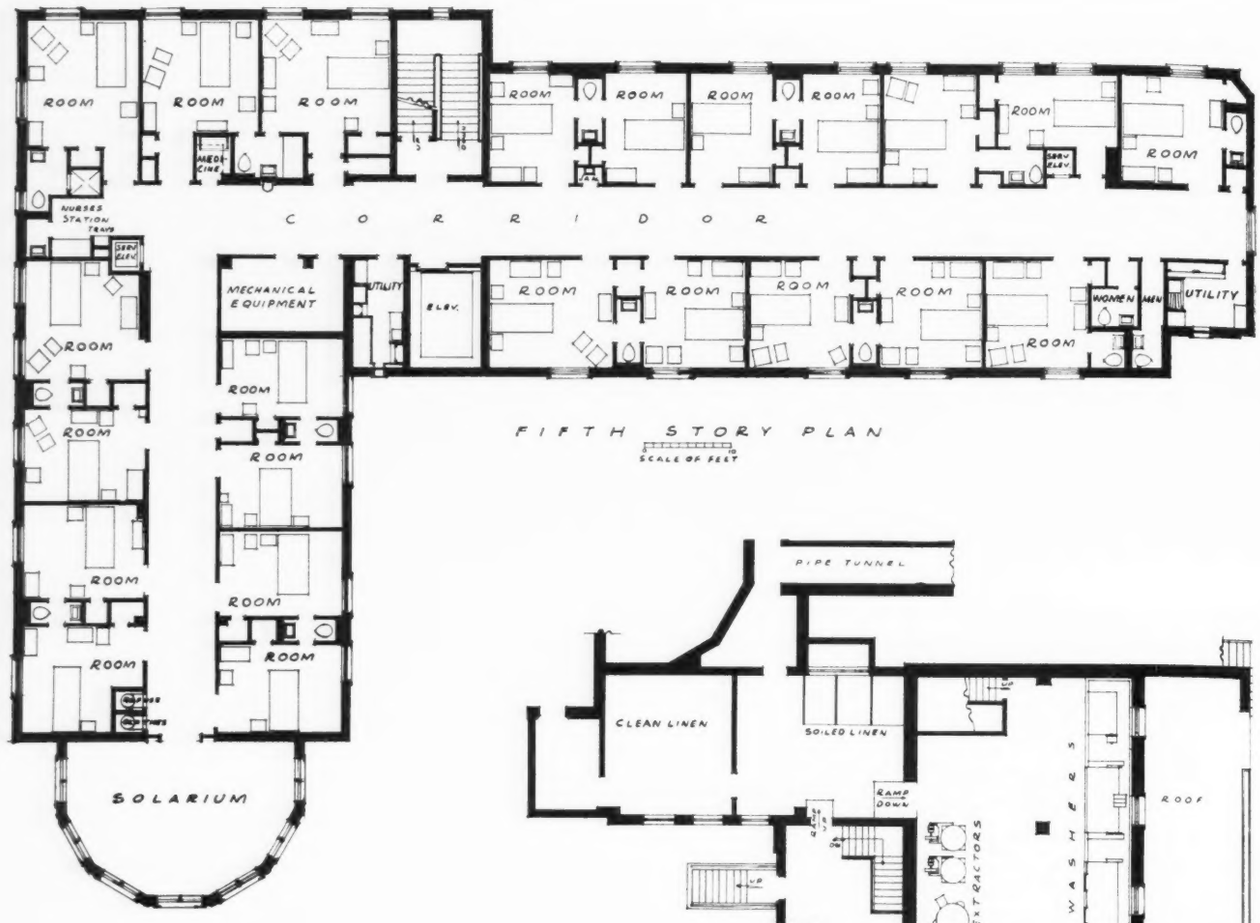


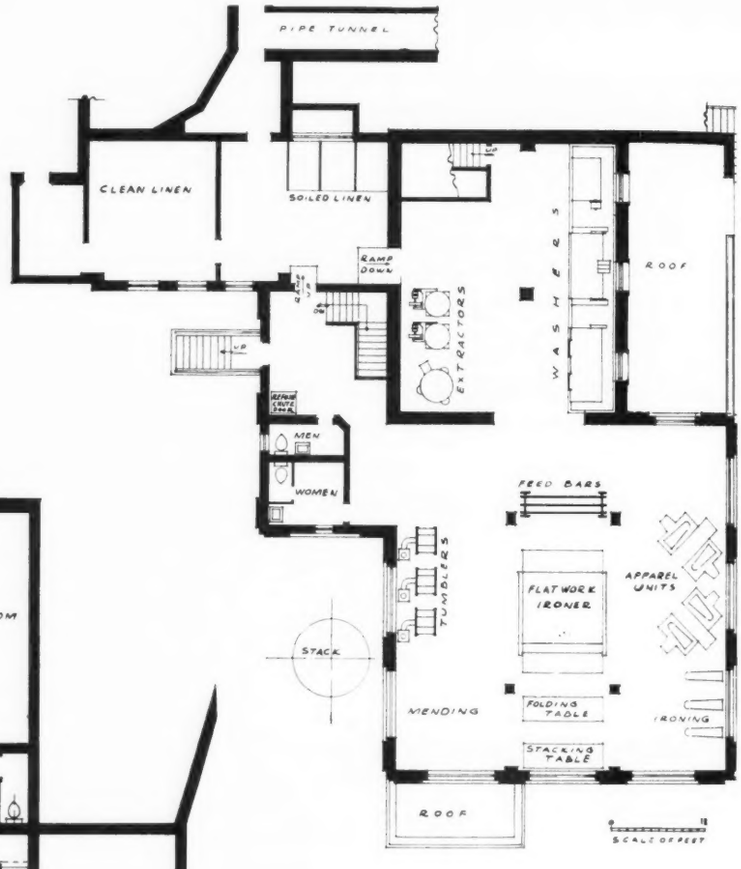
Above: One of the major operating rooms. Visitors' corridor at the end of the room is partitioned by glass blocks and plate glass. Left: Plan of fourth floor on which surgeries and the maternity department are located.

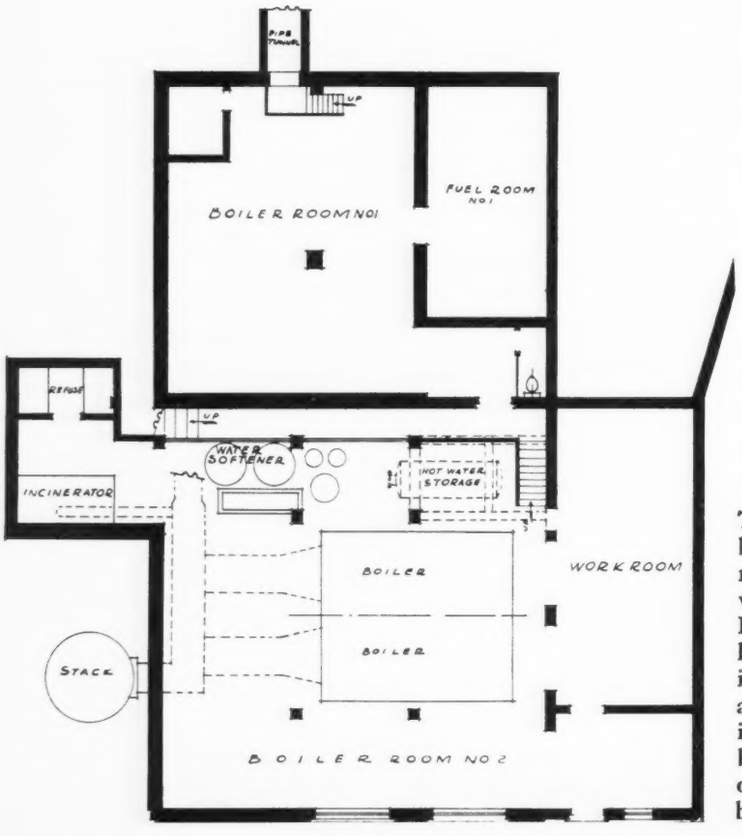


Left: Toilet room typical of those in all private rooms. The utensil cabinet is hung by gravity and also serves as access panel to pipe shaft. Right: Sterilizer room. A special feature is the glove drying drawer placed under the autoclave.

FIFTH STORY AND BOILER HOUSE—LAUNDRY ADDITION, MOLINE, ILL.







Top: Plan of the new fifth story, which adds 23 beds to capacity of hospital. All patients' accommodations on this floor are private rooms, some of which can be used as semiprivate rooms if necessary. In addition, the floor contains workrooms, a utility kitchen and a solarium. Center: Laundry and sewing room on second floor of new boiler and laundry addition. New laundry equipment includes flatwork ironers, washers, extractors and tumblers. Left: The boiler rooms. Fuel is fed into the boilers from overhead coal bins by spreader stokers. Space has also been allotted for a rabbitry not shown on the plan.

Architect's drawing of the remodeled Moline Public Hospital, Moline, Ill., showing the recently added fifth story.

OUTLINE OF CONSTRUCTION DETAILS

HOSPITAL ADDITION

GENERAL DATA: L-shaped fifth story, 40 by 208 feet; 23 private rooms, utility rooms and solarium. Emergency capacity, 35 beds.

CONSTRUCTION: Exterior, light buff face brick with Indiana limestone trim. Fireproof throughout. Concrete floor slab with pan joists. Roof, flat gravel. Partitions, terra cotta tile. Window and door frames, all steel. Interior doors, veneered oak. Entrance doors, hollow metal. Hardware, satin finish chromium.

FLOORING: Patients' rooms and solarium in west wing, terrazzo. Corridors, terrazzo base and mastic tile field. Patients' rooms in main section, metal base mastic tile. Workrooms and utility kitchens, mastic tile.

WALLS: Corridors and rooms, structural tile, finish plastered. Baths and toilets, glazed tile wainscoting. Stairway leading to roof, glass blocks. Color scheme, in patients' rooms, light peach; in corridors and workrooms, light cream.

CEILINGS: Corridors and solarium, cream acoustical tile. Rooms, batting insulated; hard plaster, painted light cream.

HEATING: Central unit heating and cooling system, thermostatic control. Three batteries of finned coils in one unit containing two sets for low pressure steam heating and one set of refrigeration coils for cooling. Cork insulated ducts, fan circulated supply to five zones. No radiation in rooms. Separate exhaust return ducts to filtering and humidifying unit for recirculation with 60 per cent outside air. Compressor unit, 15 ton capacity, for cooling with evaporative condenser on roof.

REFRIGERATION: One 10 ton and one 5 ton compressor for fifth floor air conditioning. Separate refrigerators, 8 cubic foot capacity, in utility kitchens.

ELEVATOR: Automatic, self-leveling, selective control, double doors. Speed, 200 ft. per minute, electric position signals at landings. Matched walnut cab, bronze trim, 6 by 9 feet. Two dumb-waiters.

LIGHTING: Corridor ceilings, recessed lights. Corridor and rooms, base tread lights. Rooms, spun aluminum adjustable direct and indirect wall lights. Solarium, fluorescent ceiling lights.

CALL SYSTEM: All rooms, nurses' call units, radio outlets and permanent phones.

COSTS: Building, including $5500 grant by W.P.A., $89,875. Cost per cubic foot, 77 cents, including architect's fee. Cost per bed, $3907 for 23 beds.

BOILER HOUSE AND LAUNDRY ADDITION

GENERAL DATA: Two story addition, 45 by 35 feet, containing mechanical equipment room, incinerator room, water softener and boiler room with overhead coal bin on ground floor and laundry and sewing rooms on second floor. Also space for rabbitry.

Superintendent: Marguerite N. Brooks

CONSTRUCTION: New main chimney, 110 feet high, radial tile. Building, reenforced concrete. Exterior and interior, sand float finish. Roof, flat gravel.

HEATING: Water tube boiler, 206 h.p., 200 pounds' pressure for low pressure heating and high pressure steam for three sterilizing units in surgery, maternity and central service departments. Spreader stoker.

CEILINGS: Boiler rooms, concrete pan joist. Laundry ironing room, hard board on sleepers.

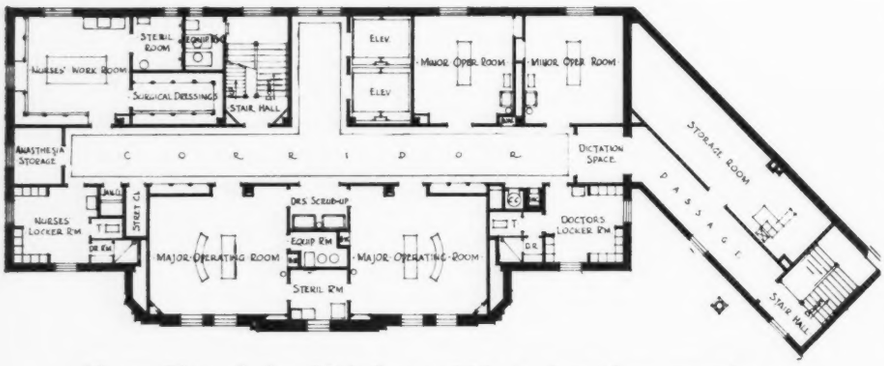
LIGHTING: Conventional drop fixtures of semidirect reflector type.

LAUNDRY EQUIPMENT: One 42 by 96 inch washer; one 40 inch extractor; one 6 roll, 120 inch flatwork ironer with ventilating canopy; one 36 by 24 inch open end drying tumbler; two 51 by 38 inch apparel presses; two single mushroom presses; lint boxes; one plain ironing board; additional work tables.

COSTS: Building and equipment, including $14,713 in W.P.A. labor and materials, $84,612.

FINANCING OF BOTH PROJECTS: General obligation bonds of city in amount of $112,500 at 3 per cent interest, spread over thirteen year period with annual maturities beginning in 1942 and $30,000 at 2 per cent interest in tax anticipation warrants payable in 1941 from a one and two thirds mills city tax levy. Balance paid from earned income.

WING, MIDDLETOWN HOSPITAL, MIDDLETOWN, OHIO



Above: Plan of the third floor, which is devoted to operating rooms, nurses' and doctors' locker rooms, sterilizing rooms and nurses' workroom. Below: The main entrance connecting the new and old wings.

Superintendent: Ada Leonard

CONSTRUCTION DETAILS

GENERAL DATA: Designed to furnish 48 additional beds and to provide larger administrative, dietary, diagnostic, x-ray, laboratory and surgical facilities.

CONSTRUCTION: Brick exterior walls with limestone trim; fireproof throughout. Floor, ribbed slabs of reenforced concrete. Interior partitions, terra cotta block. Windows, wood box frame sliding sash, except in penthouse where projected steel sash are used. Door frames, pressed steel unit frames, hospital type. Stairs, pressed steel, pan type; cement-filled treads and landings. Entrance doors, trim and canopy, stainless steel.

FLOORING: Service and store rooms, cement. Corridors, laboratories and solariums, rubber tile. Dietary section, quarry (promenade) tile. Floor service kitchens and utility rooms, ceramic tile. Corridors, solarium borders and all other areas, terrazzo.

WALLS: Entrance lobby, marble. Dietary section, fracture rooms, service kitchens, operating, sterilizing and utility rooms, matt-glazed tile. Janitors' closets, flower rooms and bathrooms, terrazzo. All other areas, hard plaster, painted.

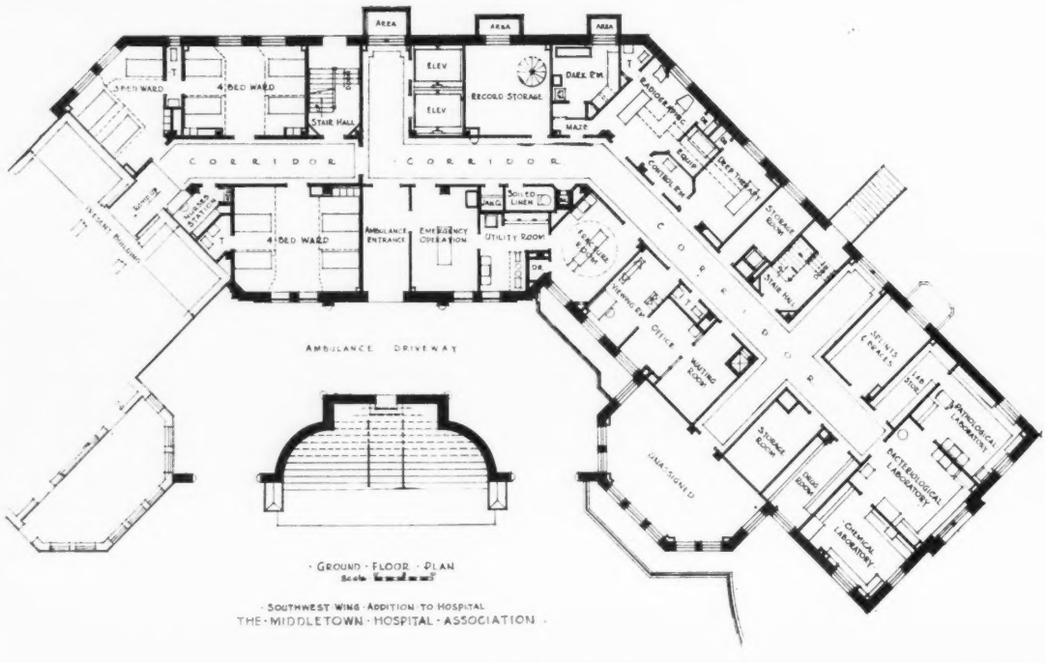
CEILINGS: Corridors, acoustical tile. All other areas, hard plaster, painted.

HEATING: Low pressure steam, vacuum system. High pressure for sterilizers; medium pressure for kitchen equipment.

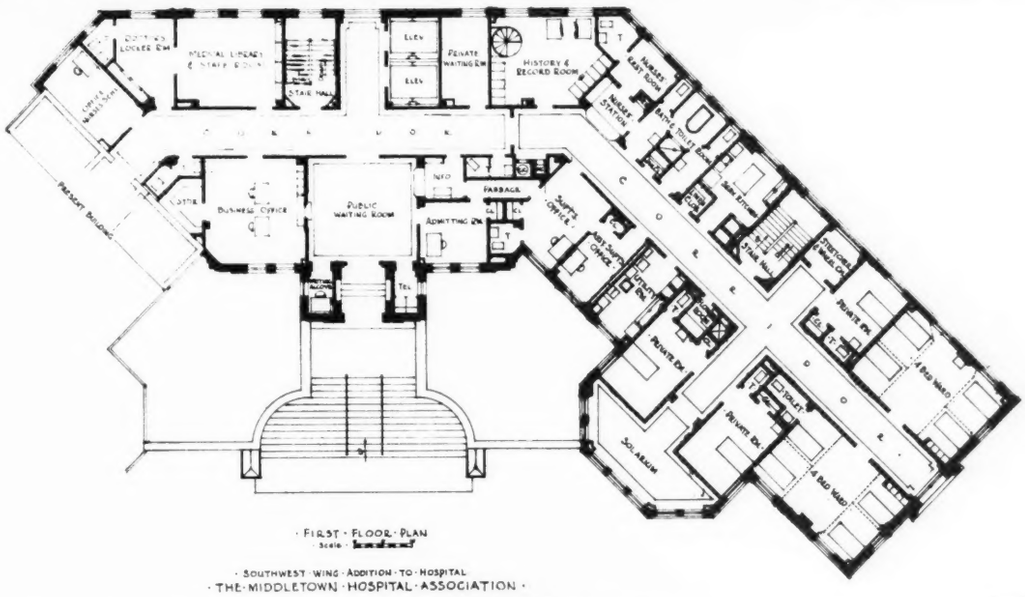
LIGHTING: Modern hospital type.

CALL SYSTEM: Lamp annunciator.

ELEVATORS: Full automatic, collective push button control. Motor-operated car and hatchway doors. Dumb-waiter, automatic push button.



Right: Ground floor plan of the new wing showing the ambulance entrance and driveway. The emergency operating room adjoins the ambulance entrance. Two 4 bed wards are located on this floor, in addition to laboratories, the x-ray department and a room for the storage of records.



· FIRST · FLOOR · PLAN
· SOUTHWEST · WING · ADDITION · TO · HOSPITAL
· THE · MIDDLETOWN · HOSPITAL · ASSOCIATION ·

Left: Plan of the first floor, which houses business and administrative offices, private rooms, wards and medical record room. Above, Left: Corridor ceilings are of acoustical tile; floors are rubber tile. Above, Right: Kitchen showing food storage counters in the foreground.

COSTS: Volume, 453,000 cubic feet. Cost per cubic foot, 77 cents. Total cost, exclusive of site, site improvement and movable furnishings, $350,000.00, divided as follows:

General structural contract	$215,000
Plumbing	23,000
Heating, ventilation, temperature control	24,000
Pipe covering	6,000
Electric wiring, signals and light fixtures	21,000
Elevators, dumb-waiters and hatch doors	21,000
Sterilizing equipment	8,000
Kitchen equipment	13,000
Refrigerators and refrigeration	7,000
Professional fees	12,000
	$350,000

Right: The remodeled lobby of the hospital looking toward the entrance. Furniture is upholstered in leather. Doors are of stainless steel.

OVERLOOK HOSPITAL, SUMMIT, N. J.

Superintendent: Louis H. Putnam

Faced with a 52 per cent increase in capacity, this hospital found it necessary to expand its facilities without actually building a new wing. Left: The new tea room designed to accommodate visitors and also for the use of nurses and doctors. It is furnished with tables and chairs of blond wood and draperies of blond chintz. The tea room was set up by a committee of the women's auxiliary.

Center of Page: The new entrance porch and steps. Above: Looking into the tea room from the reception room. Left: The new reception room made possible by a gift from Mrs. Marcellus Hartley Dodge, Madison, N. J. This addition was made by enclosing the large entrance porch. The result is a spacious glass-enclosed room that commands a splendid view of Baltusrol Mountain and the surrounding countryside.

WOMEN'S SERVICE GROUPS

Dispensary Committee Suggests Principles and Policies for Volunteers

The other day we were rereading that excellent little handbook for volunteers that was issued a year or two ago by the Pasadena Dispensary Committee, 38 Pennsylvania Street, Pasadena, Calif. In it we found all sorts of useful information regarding principles and policies for volunteers. For example:

"The minimum amount of time a volunteer should give, if she is to be really useful, is one half day a week for nine months. Therefore, all applicants are asked to sign up for this period, the first month being mutually probationary. There should be no more than two absences, for good cause only, during this time and the worker will be asked to make them up. In practice, volunteers generally work the year round, except for an annual vacation which may be anywhere from two weeks to two months, depending upon family plans, with a couple of weeks off for measles or babies. Any effort made by the volunteer to carry the dispensary work through the summer is more than appreciated.

"Too many absences would seriously impair the efficiency of the dispensary and would indicate a lack of real interest on the part of the worker, too many outside responsibilities or frail health. Such a worker would have to be replaced for the good of the dispensary until some future date when circumstances permit her to be more regular in attendance.

"The volunteer should be as regular and as punctual as if on salary. She has asked for the job and it is supposed that she will do it until she resigns. If it is necessary to be absent, she should let the chairman in charge of her department know as soon as possible so that arrangements may be made to have the work covered.

"A job must on no account be left unattended. No matter how small it is, the fact that the volunteer is there regularly to attend to it spares somebody else the necessity of worrying about it. Regularity of attendance makes for a helpful service because the worker becomes in time familiar with the doctors, the patients and dispensary routine."

On another page we discovered the following pertinent paragraph:

"Volunteer workers in an agency of this sort not only assist in the actual work of the agency but also serve as a link between it and the community. Dispensaries and out-patient departments perform definite services for the community, in return for which the community gives them support. It is only right that the community be kept informed of the amount and caliber of work that is being done, if support is to be continued. This duty is performed partly by records and reports, but it is also one of the chief functions of the volunteer workers. The volunteer can interpret the agency to the community and the community to the agency."

Finally, we believe that every lay worker should read and remember this:

"Bear in mind that there is such a thing as 'the psychology of sick people.' Some patients come here with the infirmities of old age, largely because they are lonely. This is probably their one social contact of the week. Make it pleasant for them. Others may be seriously ill; show sympathy but not pity. In explaining the doctor's instructions, speak very slowly and distinctly, because a sick person must sometimes have his thinking done for him. Always show patience and consideration, in spite of the fact that some seem to deserve it more than others. To a sensitive person driven to asking aid, courtesy is of utmost importance at all times."

Auxiliary Tells How It Obtained New Members

Every auxiliary is anxious to increase its membership. The women's group at Nyack Hospital, Nyack-on-the-Hudson, N. Y., did, and here's how they went about it. They prepared a little folder with just three words on the front cover —"Read the Story." Inside, across the two pages is printed in small type, "How Members of the Women's Auxiliary of the Nyack Hospital" and then in large yellow letters "Help the Board of Managers Get You a Better Hospital."

Beneath this heading on the one page is "What We Do" and on the opposite page, "How We Do It." The list of services rendered is too long to give here but the entire picture is presented at a glance. In the lower right-hand corner a black and white engraving shows a nurse ministering to a young patient in bed. The caption reads "Help Us Help Our Hospital."

On the last page are a plea to join the auxiliary, a list of its branches and officers and a statement by the hospital president, Charles B. Manville, to the effect that "the women's auxiliary is one of the most essential and useful adjuncts of the Nyack Hospital. Without its constantly recurring aid we would surely be handicapped in supplying highly specialized service."

Special Teachers Maintained

The salaries of a teacher for the children's ward and of a director of music for the nurses' glee club are paid by the Woman's Auxiliary of Wilkes-Barre General Hospital, Wilkes-Barre, Pa., as a part of its large contribution to the hospital. Last year the auxiliary bought 40 good card tables for the nurses' home, an electrical unit for use in the operating room and ice cream and extra comforts for distribution among ward patients during the summer months.

How About a Harvest Home Like This One at Nyack?

Too bad that members of other women's groups cannot attend the annual Harvest Home held each year by the auxiliary of Nyack Hospital.

Here is an activity that greatly benefits the hospital yet does not involve a great deal of work. The entrance is suitably decorated with corn stalks and pumpkins and the entire building assumes a festive air. Then the gifts start to arrive—most of them foodstuffs, a share of the recent harvest. Many contributions of money are received as well, this being the occasion for many to make a gift that they might otherwise feel was too small.

Visitors are graciously received and invited to go through the hospital and to have refreshments in the dining room.

It is an excellent idea for the hospital, not alone because of the gifts received but also because of the favorable publicity gained.

All for Patients

Doing something "plus" for all patients is the object of the Flagler Hospital Auxiliary, St. Augustine, Fla. Its members will supply a special nurse, for example, if one is required and the patient does not have the money for such a luxury. They furnish flowers for the patients from time to time and have a committee whose duty it is to visit them. They plan a Christmas program to include every patient, as well as the hospital employes. They do all this, and more, principally with funds raised through the promotion of a Washington's Birthday Ball.

One Sentence Appeal

"I had no shoes and complained, until I met a man who had no feet." This sentence displayed in black and red type on a 3½ by 5½ inch card helped the Charity Fund of the Temple Sanitarium, Englewood, Colo., raise a sizable fund. Temple Sanitarium is a hospital for convalescent children.

Women as Board Members

MRS. HERMAN PLAUT

Trustee, Hospital for Joint Diseases, New York City

THE rôle played by women in ministering to the sick is as old as illness itself. Yet, in the fifth decade of the twentieth century, the question still arises as to whether women can be of proper service as trustees of a hospital that has as its primary objective the treatment and cure of disease.

In order to achieve a better understanding of the question, a word ought to be said concerning a hospital's objectives. They consist of (1) the care of the sick, (2) the education of the doctor and the nurse, (3) research and (4) the eventual prevention of disease. All of these objectives, of course, are carried out by the medical, nursing and social service professions, as well as by the closely allied therapeutic services.

Beyond the activities of these various units, there is always a central and parent body that has the responsibility of enunciating policy, of introducing and maintaining standards, of establishing community relationships and of financing the hospital. These are the concern of the trustees of the hospital. Within each one of these objectives is a responsibility that for many years has also been assumed by the women's groups in their work for hospitals.

Recognition for Social Service

In the hospital structure at least one important department, the social service, has been carried on predominantly under the direct supervision of women. The far-reaching results of the activities of this department have not always received proper recognition and understanding on the part of the trustees of the hospitals, because in many hospitals they are not reported on as a part of the agenda of the regular trustee meetings. This brings us to the first reason for having at least one representative of the women's groups serve on the board of trustees.

From a talk before the United Hospital Fund of New York, 1940.

Many of the problems that are discussed by trustees at board or at committee meetings require interpretation based on the experience that has come to women through their daily contact with hospital problems and the range of their many activities related to the care of the sick. Unless that viewpoint is obtained, the deliberations and discussions of the board of trustees may not yield the desired results. This would be the second reason for having women on the board.

A woman's place is on the board of trustees, Mrs. Plaut contends, and proves her point in convincing fashion by demonstrating the peculiar fitness of women to serve in this field

Then there is the problem of finance. The hospital's deficit is, of course, a perpetual worry to the trustees. The struggle to raise the necessary funds to meet the hospital's budget each year is becoming increasingly difficult as hospital costs rise and as the demands for free service increase. Perhaps the greatest example of the rôle women play in philanthropy is the raising of substantial, as well as small, sums from a large number of subscribers, particularly from women. Notably in the great federated drives the women have been successful in broadening the base of giving and their efforts have increased the community's awareness of the needs of hospitals. This would be the third reason why women should be permitted to serve as members of a board of trustees.

Women assume responsibility not only for expenditures but also for the raising of funds to meet the expenditures. When a hospital reports on its total expenditures, it records the service rendered by volunteers with appreciation, of course, but how often does it evaluate the service of its volunteers in terms of actual savings to the hospital? Many hospitals have large numbers of volunteers at work daily who are performing tasks of essential usefulness.

An example, of which I can speak from experience, is the Hospital for Joint Diseases, New York City. Since the hospital was founded in 1905, the volunteer service has been highly developed. From a small beginning with a group of eight or ten women, the number of volunteers at the hospital today is more than 200. Their work covers an extremely wide range of activities.

Activities of Women's Group

They serve as aids throughout the hospital and its clinics; make surgical dressings; sew garments for all patients and the staff; repair linens; collect clothing, which is distributed by the social service department; knit woolen sets for children; purchase linens and blankets; furnish equipment; work in the patients' library, occupational therapy shop and thrift shop; organize and carry through an entertainment program—much needed by patients in a chronic disease hospital such as ours; plan special holiday activities, and one volunteer even painted murals in the children's wards!

These volunteers give generously of their time, energy and financial support. Service as members of numerous committees affords the opportunity for the development of leadership and, thus, the committee chairmen and officers come to their

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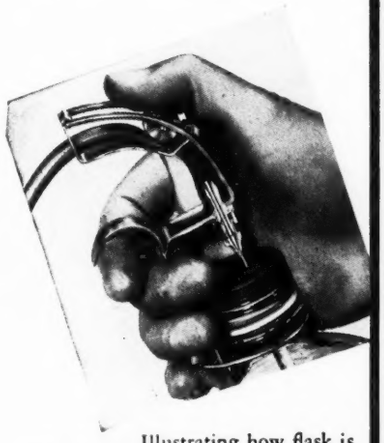

Illustrating how flask is supported and rate of flow controlled with one hand. Note: no acute angles to slow up blood flow, nor inaccessible constricted orifices to cause clotting.

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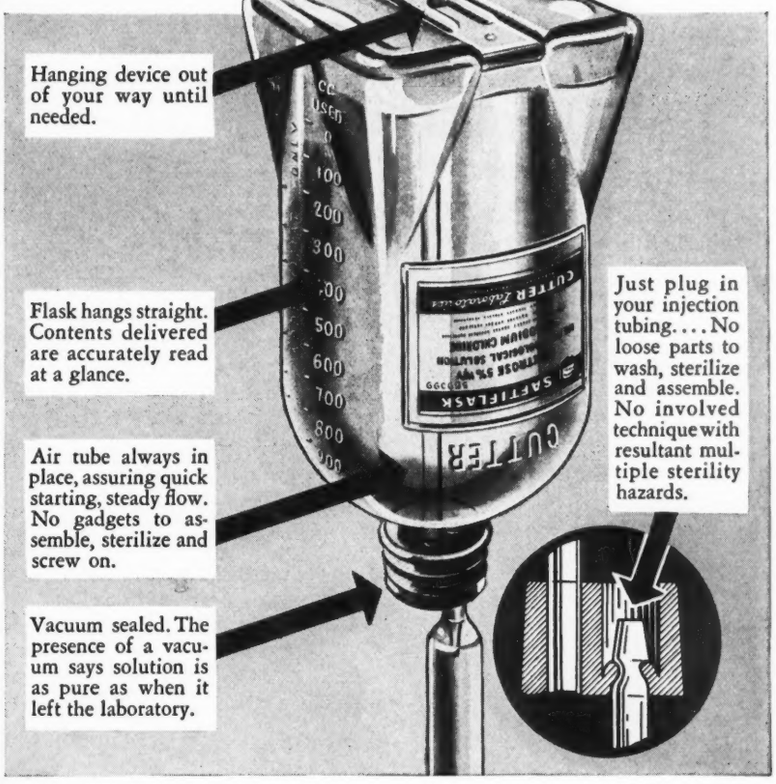
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leading positions with direct experience gained over a period of many years.

Because of that, they are able to understand the problems involved in hospital service and the rôle played by women in rendering that service. They come to know the hospital's requirements and accomplishments, as well as its difficulties. They are in the happy position of being able to help in correlating the hospital's services and, at the same time, they are competent to assist in shaping policies and practices. We would all agree that an active interest and intelligent understanding of hospital problems are the essential qualifications for a trustee—man or woman.

It is a source of gratification to observe that in many communities women are assuming greater leadership in hospital activities and more women are serving as trustees. We hope that there may never be reason to regret giving women an increased opportunity for service to the poor and the sick by letting them share the responsibility of being hospital trustees.

Thirty-Eight Years as Trustee

AUGUSTINE J. SMITH

Governor, Society of the New York Hospital, New York City

A MULTITUDE of far-reaching changes and advances in the science of medicine has taken place during my thirty-eight years as a governor of the Society of the New York Hospital. Progress has been equally marked in the lay leadership of our hospitals and medical centers. That we no longer have as much reason to fear pestilence and other causes of untimely death we owe not only to the leaders of medicine but also to these laymen whose vision and energy have, in large part, made the progress of scientific medicine possible.

The task of the voluntary hospital governor or trustee today is a complex one compared with that of three decades ago. Today we have health laws, liability laws and numerous rules and regulations affecting every part of our hospital management, none of which existed thirty-eight years ago. We have specialized clinics, progressively higher education and a trend toward medical centers that embody all the skill and equipment known to the medical world. None of these existed in the early part of this century. All of them have added to the responsibility of the hospital board.

But if his responsibilities are heavier than those of his colleague of thirty-eight years ago, still the member of a modern hospital board would do well to remember that his predecessor had many qualities that are more than ever necessary today. One has only to look over the long-hand minute book of a board meeting two generations ago to realize the extreme care, the close analysis of hospital problems and painstaking consideration of details that characterized the average board member of that time.

Never was service on the hospital board merely a matter of attending monthly meetings and discussing the institution's work. For example, the minute books of the Society of the New York Hospital show that during the War of 1812, in order to get coal for this institution, the governors negotiated an agreement with the admiral of the British fleet blockading New York.

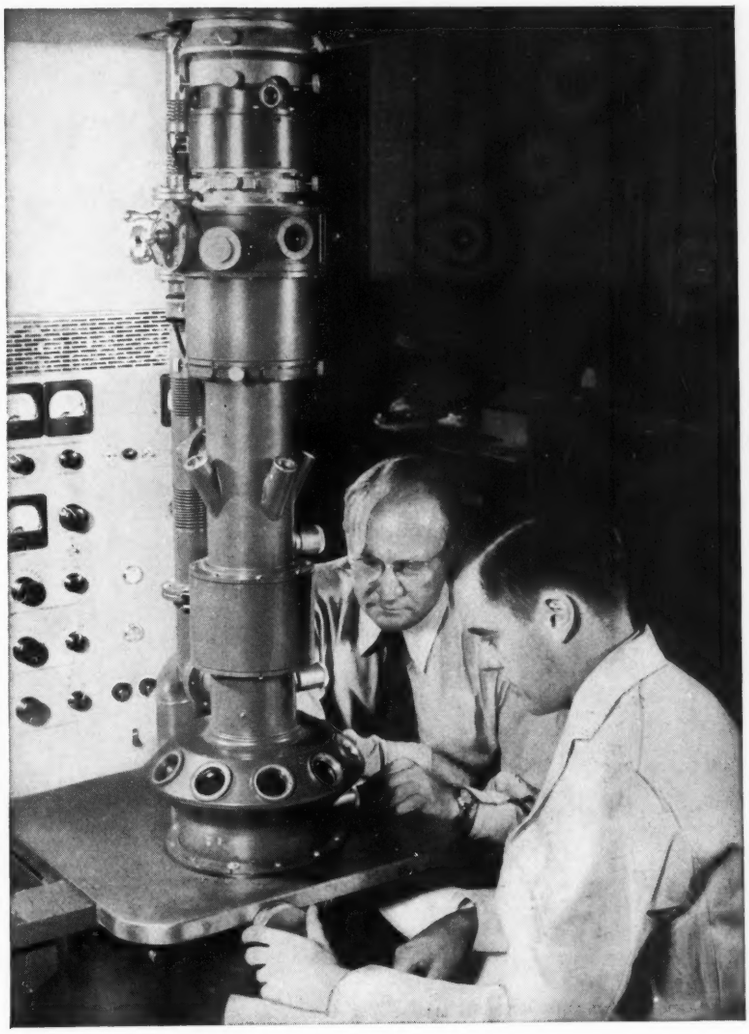
On another momentous occasion, that of the "Doctors' Riot" of April 13, 1788, they defended the institution by physical force. It was a historic step in the progress of medicine and hospitals when, in the latter part of the eighteenth century, the governors decided that a certain insane patient was to be regarded as curable, and, therefore, eligible for admission to the hospital.

In times of war these board members rendered great patriotic service. In the last war, for example, the governors of our own institution helped to equip a base hospital abroad and, in addition, arranged for the treatment of shell-shocked soldiers at the hospital's Westchester Division at White Plains. The vigorous, enterprising and public-spirited way in which these men fulfilled their duties provides an example that all of us today would do well to follow.

If it is true that numerous changes have occurred in the functions of the average hospital board, it is equally true that there are many things that have not and are not likely to change. Membership on a hospital board is today and always has been far more than an honorary position. It may best be defined as the dual responsibility of interpreting the hospital to the community and presenting the views and needs of the community to the hospital. Today this dual function is more important than ever before because of the rapidly increasing complexities of our economic and social life.

New York Hospital was chartered in 1771. Its first patients were Continental soldiers wounded in a bombardment of the city by the British fleet.

A New Aid to Suture Research



THE ELECTRON MICROSCOPE

FIFTY TIMES more powerful than the strongest optical microscope and providing useful magnification up to 100,000 diameters, the recently perfected electron microscope has greatly extended the horizon of scientific observation.

Acquisition of the first of these new instruments conforms with the DAVIS & GECK policy of providing its research staff with every possible facility.

The potentialities of an instrument which carries vision into the realm of molecules seem limitless. The electron microscope, therefore, constitutes a most important supplement to research equipment already rated among the most complete in this country.

Further details of the Electron Microscope are given on the following page

DAVIS & GECK, INC., BROOKLYN, NEW YORK

A New Aid to Suture Research

The Electron Microscope

FOR SOME YEARS it appeared that an impasse had been reached in the extension of microscopic observation. The ability to penetrate smaller and smaller fields depends not upon greater magnification—which is limitless—but upon increased resolving power, or the power of discriminating between minute objects in close proximity. Since resolution is definitely limited to the wave length of the medium of illumination employed, the maximum efficiency of the optical or light microscope was attained when it was adapted to the use of short wave ultra-violet radiation.

Efforts to explore beyond the limits of the microscope, therefore, turned to indirect methods until it was observed that a close analogy exists between the action of a glass lens on a light beam and that of an electro-magnetic field on an electron beam. This suggested the development of an instrument which, in place of light, would utilize electronic emanations of infinitesimal wave length. The outcome was the electron microscope.

IN GENERAL PRINCIPLE and in arrangement of its essential elements this instrument is quite similar to the light microscope. The electron beam is condensed, passed through the specimen, enlarged and focused upon a fluorescent screen for direct observation or upon a photographic plate as desired.

Manipulation of the electron microscope differs from that of the light microscope in that focusing is done by varying the lens power instead of changing the position of the specimen with respect to the lens. This is possible because in magnetic optics "lenses" are created and controlled by current flowing through a coil. Ability to vary the lens power also permits continuous variation of magnifying power —a marked advantage over the step by step method of the light microscope.

THE PERFORMANCE of the present instrument conclusively demonstrates its practicability and great immediate value. It permits direct observation in magnifications up to 30,000 diameters and photographic magnifications up to 100,000 diameters. Moreover, many specimens transparent to light are shown in detail by the electron beam without recourse to staining.

Experiments conducted thus far indicate that the electron microscope opens a way to medical research of profound significance.

DAVIS & GECK, INC.

Power Plant Generates Economy

JOHN F. LATCHAM and J. A. McINNIS

Business Manager and Chief Engineer, Respectively Colorado General Hospital, Denver

THE question of whether it is better to generate or to buy power is an interesting problem. Many institutions purchase their power because of the cost of additional equipment, the low utility rates available, lack of space, lack of skilled help or good salesmanship on the part of the local utility company. However, the generation of power often proves to be a worth-while investment.

Utilizing Exhaust Steam

The utilization of exhaust steam at low pressure in heating buildings and water presents an opportunity to save a considerable amount of fuel. In a well-designed hospital plant of medium or small size generating equipment can often be operated with no more help than is necessary to operate the boilers only. Steam at a pressure necessary to heat buildings still contains about 90 per cent of its original value after passing through a noncondensing engine or turbine and as the heating season is about eight months of the year in most parts of the United States a large saving can be effected. In the summer, most of the exhaust steam will be wasted to the atmosphere except for the amount required to heat water or for similar purposes.

Depreciation on most power plant equipment is low and many generating sets are in use today after twenty-five years of service.

It is not necessary for an institution's power plant to be an extravaganza in machinery but it must have certain minimum equipment to operate at a normal degree of efficiency. This should include duplicate boilers, pumps, generating units and other equipment necessary for continuous operation. If fuel is to be burned economically, the plant should have steam flow meters, draft gauges, thermometers and some kind of automatic regulation on the boilers. It is discouraging to the plant engineer to have to operate without instruments that aid in saving fuel and labor.

Turbo generators are gradually replacing engine generators except in the small sizes, owing to improved steam rates and the ability to operate almost continuously with a minimum amount of attention. As no cylinder oil is used in turbines a chronic source of trouble is thus eliminated and a saving in maintenance and oil is effected.

In the power plant of the University of Colorado School of Medicine and Hospitals in Denver, power is generated in a new turbine generator of 300 kw., 60 cycles and 2300 volts, which uses steam at 250 pounds' pressure of superheat and 3 pounds' back pressure. It is run almost continuously and has been out of service only one week in the year that it has been in use. The stand-by unit consists of a 200 kw. engine generator set now nearing the end of its usefulness because of the gradually increasing load. It is still in good condition and can be used on light loads.

An example of the saving resulting from the higher pressure is shown on the flow meter in the steam line to the turbine. It drops about 20 per cent when the pressure is raised to the higher level. All exhaust steam from it is used for heating during the winter months. In the summer months about half is wasted to the atmosphere and the remainder is used for heating water for the laundry and the hospital.

Two boilers are of a straight tube box header type of 252 h.p. and carry 160 pounds' pressure. They are fired by underfeed single retort stokers with variable speed, forced draft fans. The induced draft is furnished by a 125 foot reenforced concrete stack. The third and largest boiler, installed in 1938, is a three drum unit with a normal rating of 450 h.p. and carrying 250 pounds' pressure. It has water walls on the sides of the furnace and is fired by a spreader stoker.

Fine coal is burned in suspension while the coarser coal is burned on a flat dumping grate with small fixed draft openings installed in two separate sections which can be operated separately and are capable of carrying 125 per cent of boiler rating. Automatic controls are used to regulate the coal, air and uptake damper.

One and one-fourth inch Colorado lignite coal is burned. It has a heating value of from 9500 to 10,200 Btu. as received. It is delivered to a hopper outside the plant and then elevated to overhead bunkers whence it flows to the stokers. Our coal contract allows a 3 per cent variation from the 10,000 Btu. content of the coal as received. Monthly analyses are made by a testing laboratory.

For the first six months of 1940 the operating cost per thousand pounds of steam was 25.4 cents. This could be lowered somewhat if the night load were heavier, especially during the summer months. The plant is manned by three operators and a part-time helper. The chief engineer's time is devoted to supervising the power plant and the maintenance departments.

Condensing Water Salvaged

All drips from the boiler regulators, turbine oil cooler and air compressor jacket water are used as make-up water. During the summer months it is possible to salvage about a third of the condensing water from the refrigeration machines by returning it by gravity through the heating return lines to the power plant. This water was previously wasted to the sewer but now we are saving about 150,000 gallons per month. The heat-

ing pump is operated on a float switch and, therefore, little power is needed to handle this water.

Well water is pumped from a well 1018 feet deep at the rear of the power plant; it has a capacity of about 125 gallons per minute. It runs about ½ gram of hardness and has saved about two thirds of the hospital water bill and about 40 per cent in soap. The boilers are practically scale free and can be operated continuously for six months or more unless furnace or stoker repairs necessitate a shutdown.

As the well pump is operated by power generated in the hospital plant, pumping costs are low because exhaust steam is used for heating and a call for additional heating can often be met by starting the well pump. An underground reservoir holding 225,000 gallons of water furnishes a reserve supply and adds to the flexibility of the installation. City water is used only during the summer months for irrigation purposes.

Repair work in the power plant and laundry is done by the operators unless the job is too extensive. Since installing the large boiler in 1938 and drilling a deep well about the same time, boiler maintenance has been reduced considerably, owing to scale-free water from the well and the use of water walls on the sides of the furnace. No clinkers form on the sides of the furnace because of the lower furnace temperature. However, more water wall surface could be added to the front and rear walls at a moderate outlay and this would add considerably to the output of the boiler.

The stoker has been in use almost three years without repairs. Grates are operated by a power dump on each side, ashes being dropped into a pit under each boiler and then raked out onto an ash drag. An overhead ash bunker is conveniently located on the end of the plant so that a truck can be loaded from under the spout.

All pumps except the boiler feed equipment are motor driven in centrifugals with ball bearings and require little in the way of maintenance. The two boiler feed pumps are of the reciprocating type and pump against a head of about 600 feet.

The cost of generating the power compared with that of purchasing it from a utility company is decidedly in favor of generating power at the institution.

The purchase price of our turbo generator was $12,932. Oil consumption is approximately 15 gallons a year. Repairs are estimated at about 2 per cent a year.

The following figures show the fixed charges and operating costs for 1940:

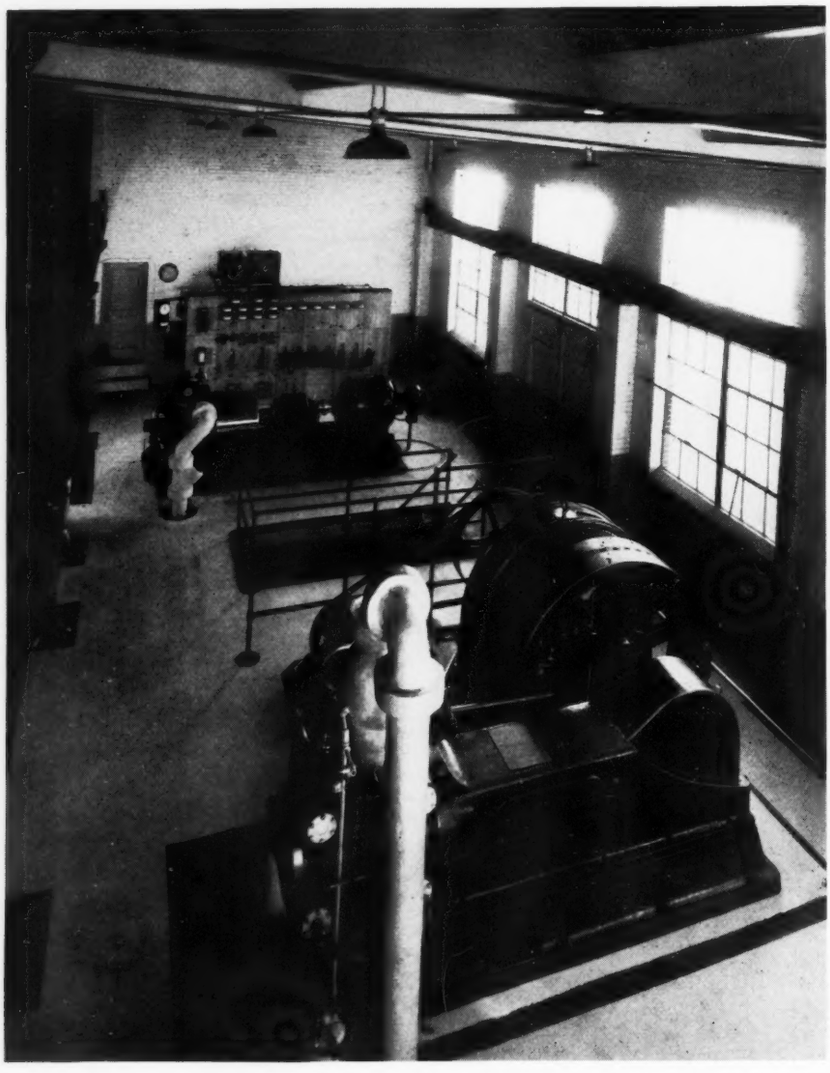
Fixed Charges:	
Depreciation at 5 per cent	$636
Insurance	00
Taxes	00
Interest	00
Total fixed charges	$636
Operating Charges:	
15 gals. oil @ 46c per gal.	$ 6.90
Repairs @ 2 per cent	258.64
Labor (additional)	00.00
Cost of 54 per cent of steam for 140 days exhausted to atmosphere in summer	2176.21
Total operating costs	$2441.21
Fixed charges	636.00
Total charges for year	$3077.75

It cost us $3077.75 to generate 1,230,600 kw. in 1940. However, had we not used the exhaust steam it would have cost $0.008 per kw., or $9844.80.

The lowest available utility rate per number of kw. used by the hospital is $0.016, or $19,689.60 per year. Should our demand increase to 1,440,000 kw. per year, a reduced rate of $0.0134 per kw. would be charged at a cost of $16,590 per year.

In 1940 we purchased 5372 tons of coal at $14,450.68. If we had not been generating our own power we would still have had to spend $12,008.93 for coal.

It can readily be seen, therefore, that we have effected a saving of $16,611.85 by generating our own power.



Interior of the power plant. The new turbine generator is at the rear.

Patients, Staff and Hospital Board

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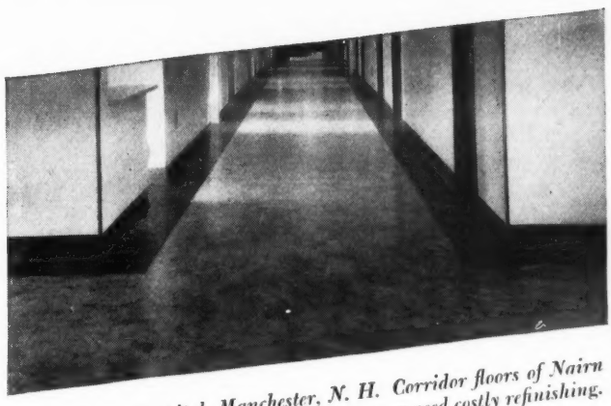
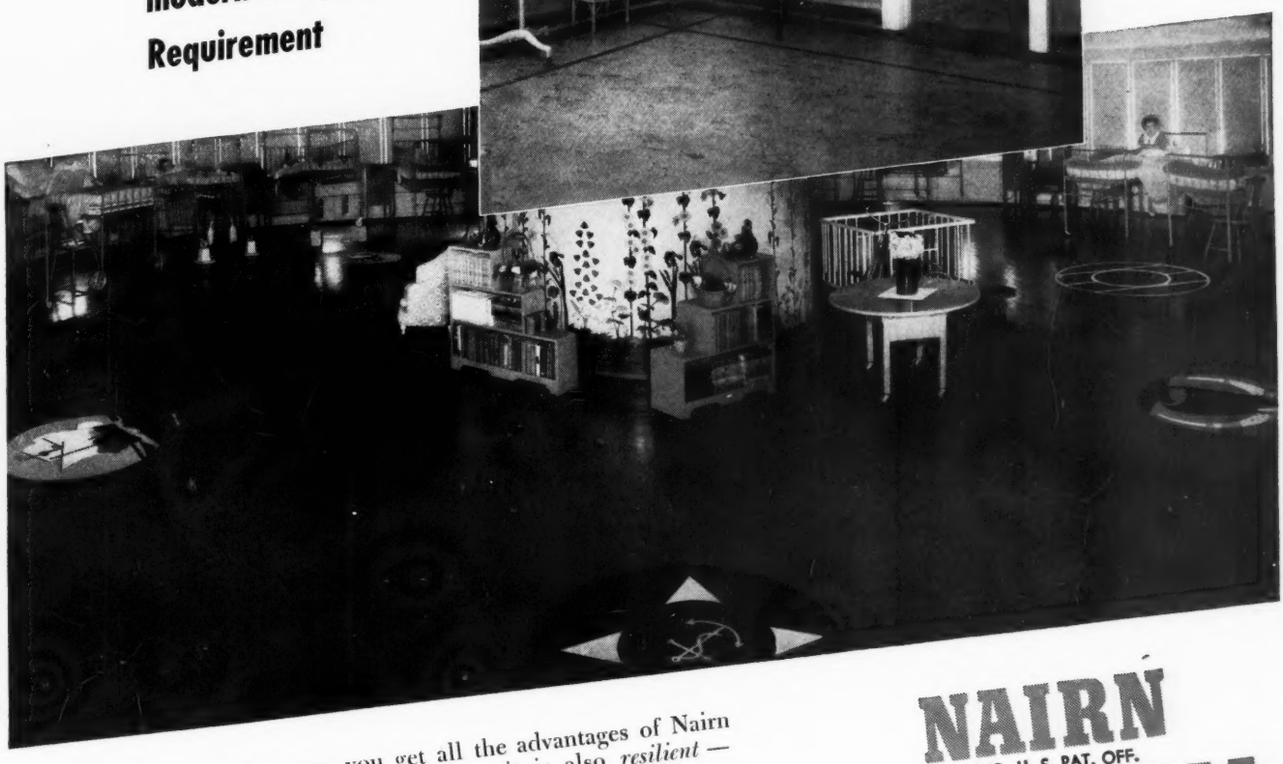


Sacred Heart Hospital, Manchester, N. H. Corridor floors of Nairn Linoleum withstand heaviest foot-traffic, never need costly refinishing.

(Directly below): The surgery room of the Latrobe Hospital, Latrobe, Pa., has highly sanitary walls and floors . . . of Nairn Linoleum. (In larger picture below): A gay children's ward in the San Francisco Children's Hospital, with custom-cut Nairn Insets.



IN no other type of floor can you get all the advantages of Nairn Linoleum. Perfectly smooth and sanitary, it is also *resilient* — quietizing and "foot-easy". For hospital *walls*, Nairn Wall Linoleum makes a permanent, easily maintained wall treatment that never has to be "done over". Like Nairn Linoleum, it is stain-proof and water-proof, easy to keep spotlessly clean. Installed by authorized contractors, Nairn Linoleum Floors and Walls are fully guaranteed. Write for free literature now.

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No Blackouts for Hospitals

J. M. CREWS

Assistant Superintendent, Methodist Hospital, Memphis, Tenn.

THE fact is now recognized by medical men and hospital superintendents throughout the country that emergency lighting is essential in all hospitals, particularly for the protection of the surgeries and adjoining rooms where a continuity of light is necessary at all times.

Local public service companies take every precaution, such as the installation of several feeder lines from different sources, to ensure uninterrupted service; however, they cannot prevent interruptions of service caused by lightning, wind and snow storms, street accidents, fires, floods or blown fuses. No community, regardless of how dependable its service, is immune from these unavoidable service interruptions.

During the past few years, few, if any, large hospitals have been planned or built that did not include, as part of the electrical specifications, an automatic emergency lighting installation of one kind or another.

The most reliable source of emergency lighting protection is equipment that is installed within the building and is not dependent upon any outside source of energy. The types of systems available are: (1) water driven generators, (2) internal combustion engine driven generators and (3) electric storage batteries.

The water driven generator is driven by the water supply of the building and is dependent upon pressure. It has the disadvantage of being subject to failure if there is any reduction in the water pressure, which may happen during a power failure.

The internal combustion engine driven generating system is satisfactory and is used when it is necessary to furnish emergency lighting for the entire building for an extended period of time. These engine generator sets are supposed to start automatically when the power fails but, because of the mechanical nature of this kind of system, they are practical only when an engineer is in constant attendance.

It is agreed by practically all engineers that the most dependable service for emergency lighting can be obtained from a storage battery system located in the building. The 120 volt type of battery system is most practical because the standard A.C. wiring fixtures can be used. This system consists of a sufficient number of battery cells to give the correct voltage; these cells are kept fully charged at all times by means of a trickle charger. Whenever an interruption occurs, the emergency circuits are automatically connected to the battery by a quick-acting, spring accelerated, gravity transfer switch, which is constructed to meet the most rigid specifications. After normal service is restored, a high rate charger cuts into service on the batteries and restores them to a full charge, at which level the trickle charger will maintain them until the next current failure.

Realizing the necessity of providing emergency lighting equipment in small as well as in large hospitals, manufacturers have made available for hospitals of less than 100 beds a special low voltage system that operates on a separate 12 volt circuit. Until a few years ago, the only battery systems available were operated on 115 volts, which made the cost of such an installation beyond the reach of the small hospital and confined it to use in the larger ones where a number of operating and work rooms were protected. This 12 volt unit consists of a 6 cell battery, which, together with the charging apparatus and automatic transfer switch, is enclosed in a metal cabinet and takes up a minimum of space. The capacity is limited to 400 watts, which is usually sufficient to take care of one operating, one sterilizer and one anesthesia room.

The storage battery system is by far the most economical to maintain, as practically no attention is needed other than the flushing of the cells with distilled water several times a year and a manual breaking of the A.C. circuit to see that the change-over switch works smoothly.

Rebuilding a Power Plant

THE Florida State Hospital, Chattahoochee, Fla., has completed a project with P.W.A. aid which will result in a completely modern and practically new steam, electric, water and ice plant.

A new boiler capable of producing 40,000 pounds per hour of steam at 425 pounds' pressure has been added, with pulverizer and accessories and with a 185 foot radial brick stack. The new building housing it completes the steam plant which includes five boilers, the smallest a 300 h.p. unit. A new 750 h.p. 750 kw. turbo-generator which operates at 425 pounds' pressure and exhausts steam at 100 pounds is in use at the institution's recently completed laundry.

Three additional generating units are included in the electric plant. In a little more than three years the cost of producing electric current has been cut from 2.25 cents per kw. h. to 9.79 mills.

In the past, Florida State Hospital has had to maintain two separate water systems. The two systems will be combined when a water filtering plant of 1,500,000 gallon daily capacity is completed. Two 500,000 gallon storage tanks are to be employed at that time.

The ice plant has been reconditioned with the addition of a new compressor and the replacement of steam-driven with electrically-driven units. Freon is now used instead of ammonia to operate the cold storage rooms at the plant, while the installation of electric refrigerators and water coolers in all buildings housing patients has brought about a substantial reduction in ice consumption.—J. H. THERRELL, *superintendent, Florida State Hospital, Chattahoochee, Fla.*

PLASMA & SERUM

prepared with BAXTER EQUIPMENT

Plasma and serum costs but little when prepared with SIMPLE, SAFE AND COMPLETELY CLOSED *Baxter vacuum equipment. Blood is drawn from donor into a Baxter Centri-Vac for sedimentation or centrifugation. The plasma or serum is then aspirated into a Baxter Plasma-Vac for dispensing, storing, or for transporting—*SEALED IN VACUUM. *Write for Brochure "PSC" containing information on preparation, and abstracts regarding use for burns, shock, hemorrhage, and hypoproteinemia, etc.*

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CHICAGO NEW YORK

Kitchen Planning in Reverse

GUY A. CARLANDER

Architect, Amarillo, Tex.

PERHAPS the most lasting impression in the mind of every discharged patient is food. When he enters the hospital he has other things to think about but, as he becomes convalescent, he is impressed more and more by food. Ask any dietitian. Food, representing approximately 10 per cent of patient-day cost and more than 50 per cent of the good will retained by discharged patients, deserves careful study and planning.

In order to produce good meals economically and to serve them hot at the bedside, a central kitchen and central service were installed at the modernized Northwest Texas Hospital, Amarillo. This system was a complete change from the central kitchen with serving kitchens on each floor that was used in the old building.

Many kitchens are the result of the arbitrary assignment of a certain number of square feet for kitchen use; then, this space is turned over to a kitchen designer whose main interest is to see how much more area can be obtained and how much equipment can be installed in the enlarged area.

Northwest Texas Hospital decided to approach its kitchen problem from an entirely different angle: first, by answering some important questions and, then, by doing a little thinking in reverse order.

Two vital questions that greatly influenced the architect were these:

Where are good meals produced for well, not sick, people at low cost? Modern cafeterias!

Where is good food prepared in the most restricted space with limited equipment? Dining cars and steamships!

Our idea, then, was to design a kitchen just large enough to accommodate all necessary equipment and to provide for its efficient operation, yet small enough to eliminate all needless steps.

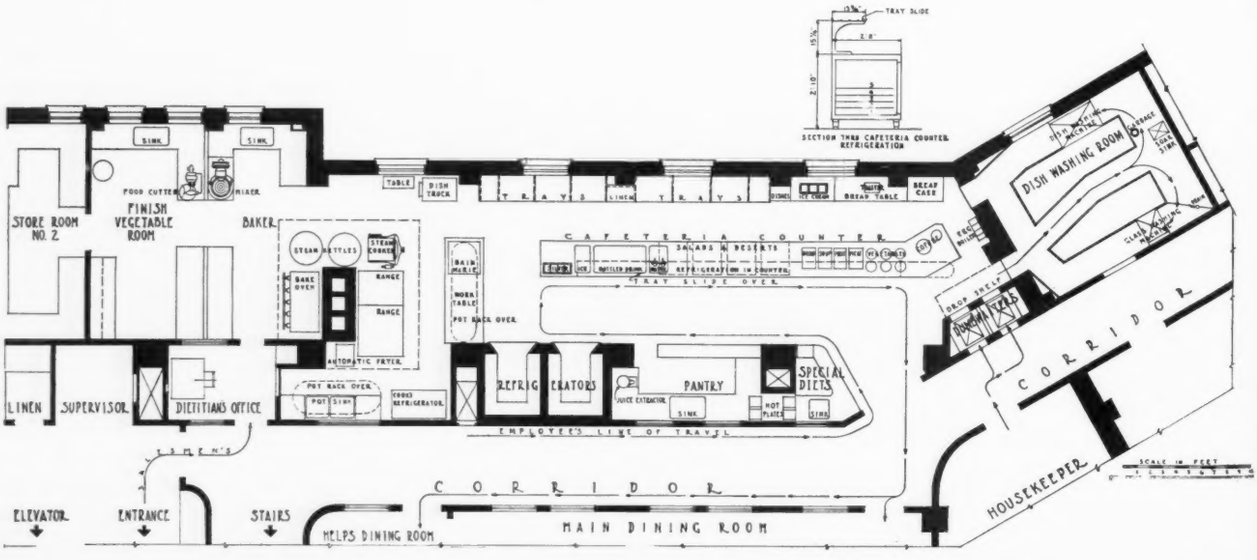
Our system of central service, therefore, comes from careful research and from personal inspections of many different types of kitchens. We learned much from Asa S. Bacon of Presbyterian Hospital, Chicago, who pioneered in the installation of this type of food service.

To decide where to locate the kitchen, we made a reverse study of food travel. Food is consumed at the bed; hence, the shortest distance from patient back to stove should produce the best food service. Dumbwaiters, therefore, must be put in the center of the floor having the greatest number of beds. Thus, the kitchen is not arbitrarily assigned a space but is located by the dumbwaiters that serve it.

The dumb-waiter shaft now located, we follow it to the first floor and have here the shipping point of food from the kitchen, a point in the kitchen plan that cannot be changed.

With one fixed station in the kitchen, we continue our study of food preparation in reverse. Did you ever take a moving picture of food preparation in the kitchen, showing every movement of the food from storeroom to patient? What we are now trying to do is to run this picture backward, unloading the full tray, item by item, dish by dish, in order to find the best location of each unit of the food department. If you want to check waste motion or useless steps, try this interesting

An architectural description of the new wing of Northwest Texas Hospital, Amarillo, appears on page 74.



YOUR INDIVIDUAL TEA

Sexton teas are chosen for the private tags of an ever growing list of discriminating hotels, clubs and institutions. Sexton teas are cured in the tea gardens of the Orient, high on the plateaus of the Himalayas, by a special process which retains the full volume of essential oils and theine found in the blossomed leaf. Sexton blends for icing are selected and packed with the same care to meet the public taste. For pleased guests and extra profit, specify SHERMAN BLEND.

SEXTON

QUALITY FOODS

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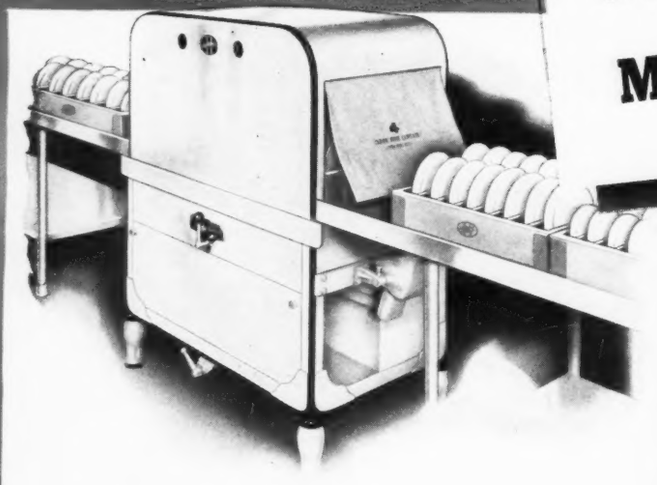
HERE'S A GOOD PLACE TO PROMOTE GOOD WILL

Make mealtime a happy event. Serve food that looks good and tastes good; and serve it immaculately. This is most essential in the case of hospital food service, where your "public" is excusably whimsical and critical. In the face of a growing "help problem", to accomplish this important objective, you need every labor-saving aid and improvement offered by modern food machines.

PUT HOBART ON JOBS MEANT FOR MACHINES!



SPARKLING DISHES . . . IN A HURRY

Hobart Dishwashers are built for "hospital standards" of performance. With proper installation and operation, they assure your effective washing of all tableware—complete cleansing, and reduction of bacteria count far below accepted public health requirements. In many models the control of time and temperatures for "safe" dishes is automatic. Every model is a HEAVY-DUTY machine with high capacity in clean dishes-per-hour—designed to get the three-times-a-day job out of the way in a hurry and release kitchen workers for other duties. Check with your Kitchen Outfitter. Make sure your dishwashing equipment is adequate.

CREATE TEMPTING, DELICIOUS VARIETY

Think of all the mechanical, routine operations in quantity food preparation that are better done by machines than by hand! Hobart Mixers with all their Attachments swiftly do a hundred-and-one jobs—improve food quality—and make it practical to serve special attractive dishes.

HOBART FOOD MACHINES

MIXERS • DISHWASHERS • FOOD CUTTERS • SLICERS • PEELERS

SEND POST CARD FOR FREE HOBART KITCHEN MACHINES HANDBOOK—THE HOBART MANUFACTURING CO., 903 PENN, TROY, OHIO

experiment of unloading a full tray by placing each item back in its original position.

Thinking backward, so to speak, brought out many helpful ideas, but in order to recheck our plans we had also to think forward and to project the picture again in normal sequence before building the kitchen.

Throughout our planning, we were guided by the compactness of the steamship and dining car kitchens, as well as by the efficiency of food service in the modern cafeteria.

System and organization have proved successful in mass production of machines, in packing plants and in canning factories, so why not systematize the mass production of meals? From the storeroom to the bedside should be one continuous line of travel for the food, with each station as complete and as simple in operation as are the stations in the production line of a modern factory.

The three general divisions of the well-planned food service function smoothly, namely, preparing, cooking and serving the food. A study of the floor plan will reveal its compactness and the use of only essential equipment. The food preparation area is complete in itself, causing no cross-travel with serving. As food is prepared, it is placed in the cafeteria counter ready for the meal.

Before a single tray is moved, the cafeteria counter is loaded ready to serve a full house. Hot foods are in the steam table; cold salads and desserts are served and placed in the refrigerated section of counter. Hot drinks are in the urns and cold drinks are in individual bottles packed in the crushed ice section. Glasses are filled with ice and water. Trays, previously set up, are now ready to serve. On the tray slide or shelf above the counter, trays are manually pushed forward as helpers fill them and are checked by the dietitian before leaving the slide.

Once the serving starts, trays can be delivered to the bedside at the average rate of four per minute. The maximum speed of six per minute is limited by the speed of the dumbwaiters and is achieved only when help of high efficiency is maintained. One hundred trays served in twenty-five minutes bring really hot food to the patient. From two to three minutes after food is placed on it, the tray is at the bedside, with hot food direct from the steam table and with salads fresh and crisp from the refrigeration counter.

One feature of the counter's refrigeration section may be of interest. Each shelf is designed as a tray shelf on which 16 salads or desserts are placed. Only one tray shelf is removed from the refrigerator at a time.

Dumb-waiters open directly into corridors on all floors. Because there is no place to put the tray except at the patient's bedside, the tray, of necessity, goes directly from dumbwaiter to patient.

After all patients have been served, the employes are served with foods of their choice from the same cafeteria counter, although separate dining rooms are provided for the usual employed groups. In a hospital for the average man, why should there be more than one kitchen or more than one cafeteria counter?

Return of soiled dishes and trays comes next. Trays come directly back from patient to dumb-waiter and then to the dishwashing room, where all sorting of dishes is done. This system reduces to a minimum noise from food service on patients' floors. Patients hear no noisy trucks or clattering dishes, and corridors are never cluttered with food or dish carts.

Kitchen floors and walls not covered by cabinets are finished in 6 by 6 inch dark red quarry tile. In setting the tile, special care was taken to ensure a full bed of mortar for each tile. Too often, cavities are left under tiles where pockets of water collect and sour, causing odors that cannot be cleared.

Above the tile wainscoting, walls are plastered and enameled in off-white color.

The dishwashing room has stainless steel troughs and machines. The floor, of quarry tile like that of the kitchen, has two large drains to ensure dryness and to make rapid cleaning possible. Walls are plastered with Portland cement and enameled.

As fast as dishes are cleaned, they are returned for storage to the position where they will be used for the next meal. Trays are washed, returned to the cafeteria counter, which now serves as a work table, completely "set up" and placed in their respective shelves ready for the next meal. Each bed has a particular tray shelf, numbered and identified with the patient.

FOOD FOR THOUGHT

"Tulip in a Pot"

A tiny favor that may be used on the Easter morning tray is the "tulip in a pot." It is made by making four slashes downward across the edges of the flat side of a round colored gumdrop, in one of the tulip colors. The slashes should not cut all the way through as the "petals" must be connected at the bottom. Spread the petals apart and attach the tulip to the end of a wet toothpick. Then cut a green jelly string lengthwise through the center to within about ¼ inch of the end. These become leaves after they are spread apart. Press the toothpick with flower attached through the solid uncut end of the jelly string and your tulip is complete. Place the flower in a marshmallow flower pot.

Flatware of Stainless Steel

Stainless steel flatware has been substituted for silver in the communicable disease unit of the University of Chicago Clinics. It can be boiled without detriment and does not stain. Chromium covers are used for plates on this unit. A medium priced china has recently been purchased for the communicable disease service because the gold on the private patients' china service would not tolerate persistent boiling. The patients are vastly cheered by the pretty pattern on the new china. Their favorable reaction to it has led Ella Marie Eck, chief dietitian, to procure additional stock for use on the neurological division, where it may have a certain therapeutic value.

Opaque Cupboard Doors

By painting the glass in the cupboard doors in the dietitians' suite, University of Chicago Clinics, an effecf of greater neatness has been achieved. The staff can now keep its reference books, professional magazines, pamphlets and records out of sight and away from dust accumulations and, if the piles do not align well, the office visitor is none the wiser.

Special Courtesies Pay

The plan at Princeton Hospital, Princeton, N. J., whereby nurses on their days off may order their break-

(*Continued on page* 96)

Personnel Pays Cash—and Likes It

LOUISE WILKONSON

Chief Dietitian, Barnes Hospital, St. Louis

THE dietary department of Barnes Hospital, St. Louis, was twenty-five years old this past year and, except for replacements of various pieces of equipment and general repairs, it looked much the same as when it was first opened. The general arrangement of the kitchen was satisfactory enough but we had reached the crossroad where a decision had to be made concerning the handling of our special diets, our dining rooms and many of our policies. We were obliged to make some changes to keep up with the times, changes that have taken place in other departments of the hospital.

Accordingly, during 1940 extensive changes were made in the dietary department and the refrigerating system. Our two kitchens were combined into one main kitchen in which most of the food for patients and personnel is prepared. Metabolic diets are prepared in a special kitchen. This enabled us to adopt a master menu with an improvement in the quality of food and the efficiency of its preparation.

The ice boxes were obsolete and the hospital was using brine refrigeration entirely. The brine refrigerators were replaced by electrical units except in the main kitchen. The hospital was also purchasing ice. A small efficient plant that furnishes ice and refrigeration for the kitchen refrigerators and also cools the hospital drinking water was installed adjacent to the kitchen.

Perhaps the most notable change was the installation of a pay cafeteria for our personnel. This was made by combining our dining room space into one large cafeteria on the first floor of the service building.

We had been using cafeteria service in the employes', students' and graduate nurses' dining rooms and had had waitress service in the head nurses' and dietitians' dining room and for the interns. So far as the food service for the personnel was concerned we had the same problems that other hospitals that give maintenance to their employes have always had. We had many complaints about food being "no good." This was a favorite term applied to food on the dislike list of many of our customers and we had more waste from the dining rooms than we felt was justified. Our employes were permitted extra servings of food, a privilege that we felt some of them exercised not wisely, but too well.

For some time the pay cafeteria system had been in the back of our minds and on occasions when food problems became particularly acute we brought the idea forward for discussion, wondering how we could

Right: Taking the "long view" of the recently installed pay cafeteria at Barnes Hospital. The electric cafeteria counter is 40 feet long. Below: Close-up of the salad section of the counter. Salads have become a popular feature of the daily menu.

RY-KRISP
HELPS SOLVE 3 DIET PROBLEMS
An all-rye bread . . . safe in allergy diets
Only 23 calories . . . fine in low-calorie diets
Whole-grain food . . . valuable in normal diets
RY-KRISP
IN ALLERGY DIETS
This Candied Apple Betty, made with Ry-Krisp, can be enjoyed safely by those allergic to wheat, milk or eggs. Tested recipe included in Allergy Diet booklet offered below.
IN LOW-CALORIE DIETS
Using the Low-Calorie Diet booklet offered below, it is easy to plan for overweight persons, satisfying meals like this...hamburger patties, broiled tomatoes, green beans, corn, Ry-Krisp.

In Allergy Diets. Because it is made simply of pure whole rye, water and salt, Ry-Krisp is a safe bread to include in wheat, milk and egg-free diets. Also a safe ingredient when crumbled and used as flour in preparing many wheat-free dishes.

In Low-Calorie Diets. Ry-Krisp is indicated in low-calorie diets because each wafer yields only 23 calories, furnishes 7 International Units vitamin B_1, is an economical source of energy and provides bulk to help stimulate natural elimination.

In Normal Diets. Being a whole-grain food, Ry-Krisp is a desirable all-purpose bread for staff as well as patients. Baked by a special process to bring out the full rich flavor of rye, Ry-Krisp is as delicious as it is wholesome.

ECONOMICAL . . . 4 wafers cost only a penny

READY-TO-SERVE . . . Always fresh and crisp

Packed in 48—3-oz. wax wrapped packages

FREE TO HOSPITALS

Allergy Diets . . . including lists of allowed and forbidden foods and tested recipes for delicious wheat, milk and egg-free dishes.

Low-Calorie Diets . . . 1700 calories for men, 1200 for women. Allow weight-loss of about ¼ pound a day. Wide choice of foods. No special cooking. Supply all dietary essentials with possible exception of vitamin D.

RALSTON PURINA COMPANY
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Please send ____ copies Allergy Diets, ____ copies of Low-Calorie Diets and samples of Ry-Krisp. No cost or obligation.

Name _____

Position _____

Hosp. _____

City & State _____

(*Offer good only in U. S.*)

The room in which the cafeteria is located is large, light and airy, with a seating capacity of nearly 300. Walls are painted light buff and light venetian blinds and colorful draperies complete the decoration.

fit it into our scheme of things. We felt that this type of service had many advantages and would, no doubt, help us to solve some of our difficulties.

It also appeared to be an opportunity to enhance employe morale by offering a choice of food rather than forcing individuals to eat certain foods as they were placed on the menu. It is evident from the satisfaction that has resulted from the change that neither the quality nor the quantity of food we were giving was really at fault but that the factor of personal choice was playing an important part.

We started to investigate the pay cafeteria service by visiting hospitals that had changed to this service. These investigations gave us many good ideas and each one of us had an opportunity to contribute suggestions when an architect was selected to draw up plans for remodeling our dining rooms. One whole floor of our service building, which included four dining rooms and four serving kitchens, was completely remodeled so that we now have one large room, one small guest dining room and one serving kitchen.

The room in which the cafeteria is located contains approximately 5300 square feet. It is light and airy inasmuch as it has four exposures. The walls are a light buff color, with light venetian shades and colorful draperies. The brown linoleum topped tables and the chairs had been in use before but they work in nicely with the cafeteria setup. The seating capacity of this room is close to 300.

Our electric cafeteria table is stainless steel and is 40 feet long. In our line-up we have provided for a 4 foot ice pan and nine sections with interchangeable frames so that we may use deep containers, long flat pans or half size pans for displaying hot food.

The ice cream dispensing cabinet is located adjacent to the serving line close to the desserts and the beverages are last. Milk is dispensed in half pint bottles and coffee and tea are sold either by the cup or by the pot.

The menus are planned with a great deal of care and the same principles are applied as are used in any other type of menu planning. Particular attention is given to color combinations, variety of flavor, texture and appearance. While we try to have as little repetition as possible certain items appear on the counter each day. A small dish of hard cooked eggs is put on the salad counter at noon and at night. We have a plate of triangles of sliced American cheese arranged on toothpicks for easy handling that has proved most popular. One other popular item that we have three times a day is a big wooden bowl filled with fresh fruit. Oranges, apples, bananas, tangerines and other fruit in season that can be sold for three cents are put in the fruit bowl.

The menu affords a good variety. At breakfast we have several kinds of fruit juice, always including orange and tomato juice. There are always one hot cereal and about 10 varieties of prepared cereal in individual packages from which to choose. Only one meat is offered and eggs are prepared in one way only as we do no short orders; doughnuts, sweet rolls and toast are served some days and on others we may have hot cakes, French toast or coffee cake for variety. There are always one fresh fruit and one stewed fruit.

For the noon and evening meals we have one soup, two or three meats, potatoes and potato substitute, two or three vegetables, from three to five salads, two varieties of ice cream and three or four other desserts.

We have been pleased to see how well some of the items on the counter have been accepted. Fruits and fruit juices, vegetables, salads, whole grain cereals and whole wheat bread sell unusually well. Too, we have had the experience of seeing some of the formerly despised foods, such as macaroni and cheese, baked beans, black-eyed peas and bread pudding, turn out to be favorites with some customers now that they can select them as they want them.

We have not eliminated all food problems by the change in our method of service as our customers must necessarily come in what we call "rushes." Student nurses coming from class, medical and dental students and some of the personnel coming from floor duty necessarily come in groups. In some instances this grouping may cause a delay in getting through the line but this traffic problem has been largely eliminated by having a checker stationed at the end of the line and a cashier by the door. Interns, student nurses and student dietitians have meal tickets that are punched when they present their checks; all of the other personnel pay cash.

Breakfast is better for everyone when you serve KELLOGG'S INDIVIDUALS

★ The patient is pleased, the kitchen is pleased, even the budget is pleased when Kellogg's Individuals go on the breakfast menu regularly. Patients like the freedom of choice, the generous portions, the fresh cleanliness of an individual package. The kitchen likes the saving on work and fuss. The budget likes the accurate cost-control and elimination of waste.

Be sure to specify Kellogg's Individuals when you order. Your wholesale grocer always has a fresh supply. Packed 50 individuals or 100 Assorted to the case.

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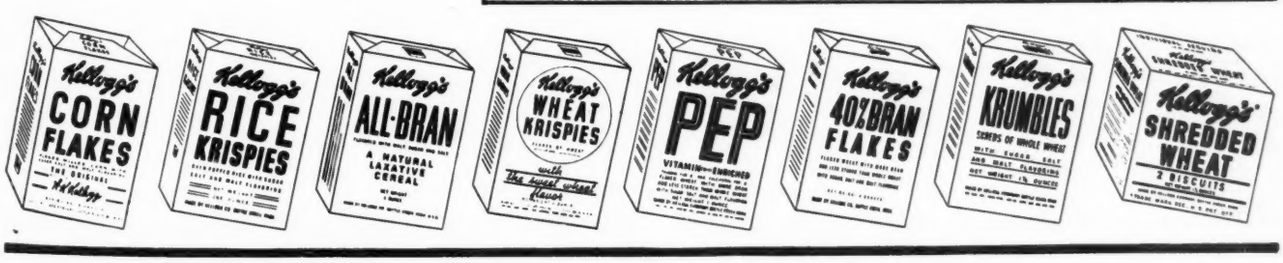
AS THEY DO AT HOME... LET YOUR PATIENTS TAKE THEIR CHOICE OF...

Kellogg's CEREALS
MADE IN BATTLE CREEK



HOLIDAY TRAY DECORATIONS

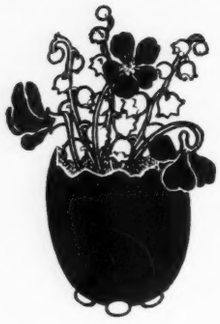
Suggested by New Jersey Dietetic Association

Right: Use an empty white egg shell, with blue stickers for eyes and a red sticker for the mouth. The hair is of yellow crepe paper (two pieces, 10 by 1½ inches) clipped in ⅛ inch strips within ⅜ inch of the edge. The cap is a white paper doily, 3½ inches in diameter. The bow is lavender crepe paper, 1 inch wide. The stand is a soufflé cup, 1⅜ inches in diameter, covered with lavender paper.

Left: The base is a circle of cardboard, 3 inches in diameter. The wire handle (11 inches) is covered with yellow crepe paper. A strip of yellow paper, 1½ by 12½ inches, is pasted to the cardboard, with a lace paper doily on top of the crepe paper. The egg shell is dyed lavender; there is a green ribbon bow.

Right: Face is painted on empty egg shell set in covered soufflé cup. The bunny's ears are cut from pink tinted drawing paper.

Left: An empty egg shell, dyed lavender, is glued onto yellow cardboard, 3½ by 2 inches. The yellow chicken is 2 inches high.



Left: Glue three navy beans on an empty white egg shell. Beans are painted black. Fill the shell with water and small flowers. Sand may be used to weight the shell to keep it from turning over.

Right: A card of the identical size is placed on top of a penny chocolate covered candy bar that is covered with tin foil. Glued to it is an empty egg shell dyed lavender with a small yellow chicken on top. A green ribbon, ¼ inch wide, helps to hold the egg in place.

FOOD FOR THOUGHT

(*Continued from page* 91)

fast brought to the nurses' home ready for preparation any time they may desire contributes materially to happier living conditions. This is just one of the privileges that may be granted in the small hospital, according to Genevieve E. Corrigan, dietitian.

"Resident nurses not feeling well enough to work but not sick enough to be admitted to the hospital may have any special food they desire sent on a tray from the dietary department to the nurses' home. The food is served hot and as attractively as our private patients' tray service, thus giving the girls a greater appetite than if they had to prepare the food themselves. Also, they rather like the idea of a tray in bed occasionally, particularly when not feeling up to par," Miss Corrigan reports.

Private patients at Princeton are allowed to order any food they may desire at no additional cost. For years, both private and semiprivate patients have had this privilege and seldom does anyone abuse it.

"For the first few days of their illness," Miss Corrigan tells us, "patients frequently have a desire for certain foods. After a few days they invariably order what is on the menu, sometimes with a few minor changes. Particularly appreciative of this courtesy are those who are in the hospital a long time. The contentment of our patients and their feeling of good will far outweigh the slight additional expense."

Inventory Suggestion

A business office suggestion is being tried out in the food service department of the University of Chicago Clinics. Dishes, silver and linens for trays and tables are being checked on the basis of a numerical standard rather than on value. The idea is that fluctuating prices of this equipment will no longer affect the inventory.

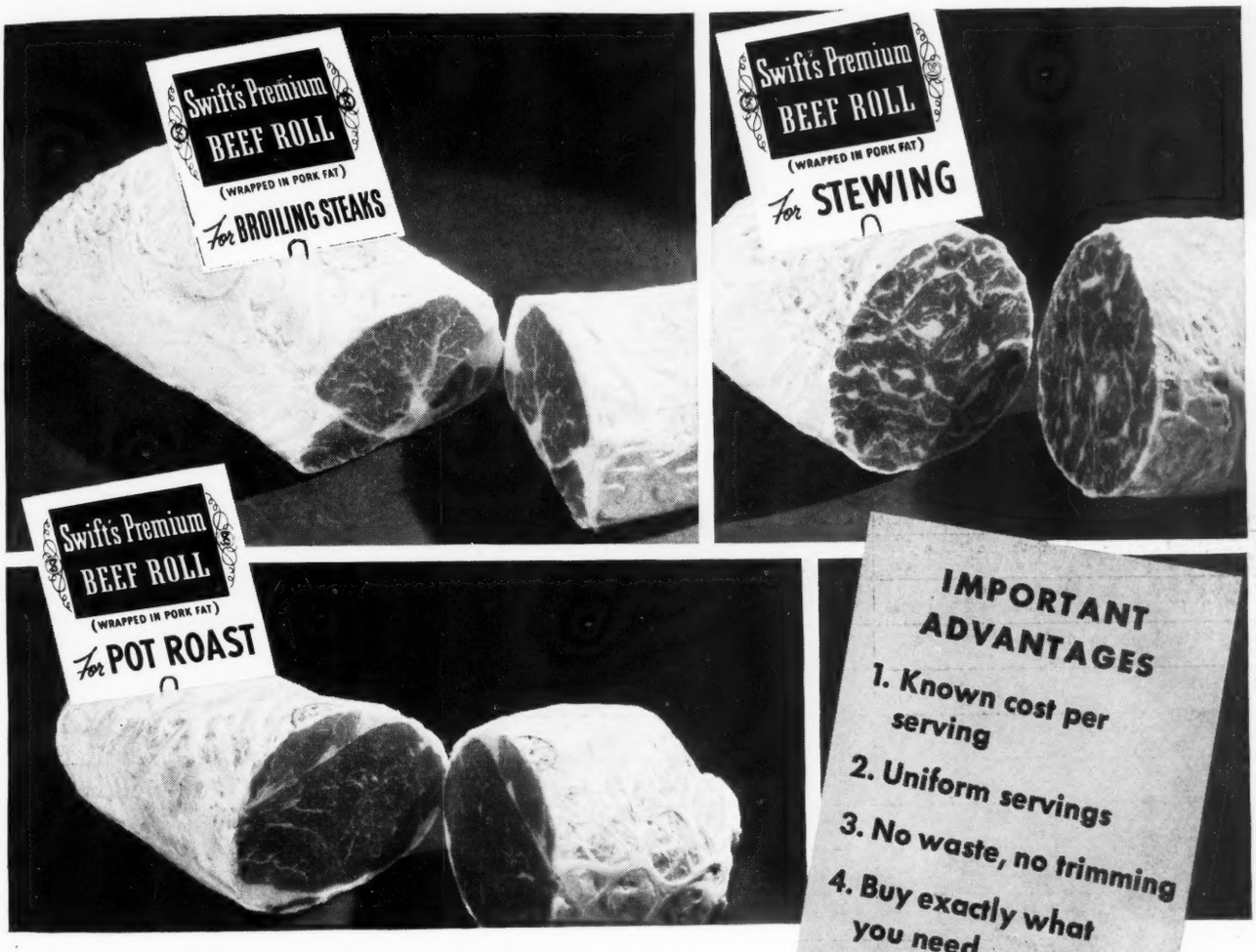
Tryout of Ward Selective Menus

Selective menus for ward patients were tried at the University of Chicago Clinics but were dropped after one month's trial. Ella Marie Eck, chief dietitian, abandoned the scheme for two reasons. In the first place, distribution and tabulation of the next day's menus proved to be a time-consuming task. Many patients were illiterate and had to have their choices marked for them; others were old and with failing eyesight and required similar attention. Moreover, the food carts in use lack the space to accommodate the additional items of food necessary in offering a selective menu.

SWIFT & COMPANY OFFERS

BONED AND WRAPT BEEF!

The cut you want in the quality you want . . boned, trimmed, quick-frozen



3 of the items Swift offers in Boned and Wrapt Beef. Each item is made from the individual muscles of the beef, wrapped in thin fresh pork fat, quick-frozen and ready for cooking.

●Here at last is a really economical, accurate way to buy beef. A way that permits you to know in advance the exact cost per serving . . . to order just the amount you need . . . to make individual servings of uniform size and quality.

Boned and Wrapt Beef was originated and wholly developed by Swift & Company. A number of different beef rolls are available, each made from a different type of cut. They range from Broiling Steak Rolls, made from the tender muscle of the heart of the rib, to Stewing Beef Rolls, from small lean muscles. Each roll contains only solid, edible meat wrapped in thin fresh pork fat, quick-frozen, ready for cooking. There is no gristle, no bone, no excess fat.

Boned and Wrapt Beef is available in four different quality brands: Swift's Premium, Swift's Select, Swift's Arrow, and Clover. You purchase by brand name, and are assured of the tenderness and flavor you expect.

Your Swift salesman will be glad to get you the full story on this modern, accurate way to buy beef. Ask him about it!

April Menus for the Small Hospital

Mary E. Hines
Dietitian, Parkside Hospital, Detroit

	Breakfast		Luncheon or Supper				
Day	Fruit	Main Dish	Soup or Appetizer	Main Dish	Potatoes or Substitute	Vegetable or Salad	Dessert
1.	Grapefruit	Creamed Chipped Beef on Toast	Consommé	Chinese Omelet		Tomato Salad	Baked Ginger Pears
2.	Orange	Bacon and Eggs, Toast	Cream of Corn Soup	Ham Loaf	Spinach Soufflé	Coleslaw	Pineapple Custard
3.	Applesauce	Canadian Bacon, Toast	Cream of Pea Soup	Salad Plate: Potato Chips, Sliced Tongue and Cheese		Molded Fruit Salad	Spice Cup Cakes
4.	Bananas	Scrambled Eggs, Toast	Tomato Juice	Salmon and Noodle Casserole		Vegetable Salad	Prune Whip
5.	Orange Juice	Creamed Eggs, Toast	Fruit Cocktail	Barbecue Corned Beef (Canned)	Stuffed Baked Potato	Asparagus Salad, French Dressing	Spanish Cream
6.	Stewed Peaches	Bacon and Eggs, Toast	Julienne Soup	Chicken Croquettes	Creamed Peas	Fruit Gingerale Salad	Angel Food Cake
7.	Tomato Juice	Scrambled Eggs, Whole Wheat Rolls	Grapefruit-Pineapple Juice	Hot Roast Beef Sandwiches		Beet Relish Salad	Assorted Gelatin Blocks With Cream
8.	Grapefruit	Bacon, Wheat Muffins	Grape Juice	Cheese Fondue	Buttered Broccoli	Waldorf Salad	Date Cookies
9.	Orange	French Toast With Maple Syrup	Scotch Broth	Mushroom, Pea and Egg Casserole	Fried Noodles	Olives and Celery	Strawberries and Cream
10.	Royale Anne Cherries	Bacon and Eggs, Toast	Cream of Celery Soup	Italian Spaghetti With Meat Balls		Vegetable Salad, French Dressing	Rhubarb Sauce
11.	Fruit Compote	3 Minute Eggs, Toast	Tomato Juice		Potato Chips	Tunafish Salad	Apricots and Arrowroot Cookies
12.	Baked Apple	Creamed Chipped Beef on Toast	Pineapple Juice	Vegetable Gumbo With Rice		Head Lettuce Salad	Graham Cracker and Marshmallow Custard
13.	Grapefruit	Scrambled Eggs, Toast	Lentil Soup With Croutons	Bread and Butter Sandwiches, Using Banana Bread		Stuffed Prune and Orange Salad	
14.	Mixed Fruit Juice	Bacon and Eggs, Toast	Spiced Fruit Cup	Escalloped Veal and Tomatoes		Coleslaw	Orange Cup Cakes
15.	Applesauce	Canadian Bacon	Beef Bouillon	Luncheon Eggs		Asparagus Salad, French Dressing	Canned Peaches
16.	Virginia Baked Pears	Cheese Fondue, Toast	Cream of Spinach Soup	Dutch Vegetable Hash		Head Lettuce, Piquant Dressing	Sliced Oranges and Sugar Cookies
17.	Stewed Apricots	Baked Corned Beef Hash, Toast	Cranberry Juice Cocktail	Crisped Bacon and Baked Hominy		Molded Mexican Slaw	Caramel Custard With Top Milk
18.	Grapefruit Juice	Codfish Cakes, Toast	Southern Bisque With Whole Wheat Croutons			Waldorf Salad	Meringue Spice Cake
19.	Prune Juice	Shirred Eggs	Fruit Cup	Escalloped Ham and Macaroni		Head Lettuce	Chocolate Spanish Cream
20.	Orange-Apricot Juice	Raisin Toast, Apple Butter	Tomato Juice	Chicken Loaf	Potato Chips	Buttered Fresh Asparagus	Ice Cream With Strawberry Sauce
21.	Royal Anne Cherries	Economy Omelet, Toast	Cream of Tomato Soup	Asparagus Loaf With Crisp Bacon, Cream Sauce		Radishes and Celery	Baked Fruit Tapioca, Whipped Cream
22.	Grapefruit and Orange Sections	Brains and Eggs, Toast	Cream of Corn Soup	Cold Cuts		Molded Vegetable Salad	Baked Apple With Cream
23.	Grape Juice	Bacon, Bran Muffins	Julienne Soup	Turkey Shortcake		Grapefruit-Cherry Salad	Butter Cookies
24.	Canned Pears and Strawberries	Canadian Bacon, Toast	Cream of Potato and Onion Soup With Cheese Straws			Molded Fruit Salad	Cup Cakes
25	Stewed Prunes	Creamed Eggs, Toast	Cranberry Juice Cocktail		Potato Chips	Salmon Salad	Fruit Cup
26.	Stewed Rhubarb	Scrambled Eggs, Toast	Jellied Consommé	Casserole of Chipped Beef, Noodles and Mushrooms		Sliced Tomatoes	Sponge Cake, Peach Sauce
27.	Orange	Bacon and Eggs, Toast	Asparagus-Pea Soup	Diced Ham in Pimento Cheese Sauce on Toast		Lettuce With Chutney Dressing	Canned Pineapple
28.	Tomato Juice	Bacon, Quick Coffee Cake	Vegetable Soup With Buttered Toast			Cottage Cheese and Chives Salad	Applesauce and Gingerbread
29.	Bananas	Wheat Cereal, Raisin Toast	Cream of Celery Soup	Deviled Eggs		Stuffed Tomato Salad	Strawberries and Cream
30.	Italian Plums	Bacon and Eggs, Toast	Grape Juice	Corned Beef de Luxe		Carrot Salad	Pompadour Pudding

Recipes will be supplied on request by The Modern Hospital, Chicago. Space precludes listing of cereals, several varieties of which are always offered for breakfast.

HOT FOOD FOR BUSY DOCTORS AT ANY TIME OF DAY

. . . IS EASY WHEN YOU HAVE A TOASTMASTER WARMER!

Food grown cold is no food to serve to tired surgeons or nurses who've been busy through mealtime—there's no need for it when you can keep everything deliciously piping-hot *for hours* in a TOASTMASTER Roll and Food Warmer. Just put in the food as it comes from the oven—on individual serving plates, if you wish—take it out any time later and it will look and taste just as fresh and appetizing as though cooked to order.

The miracle of the TOASTMASTER Warmer is that its heat principle (patented) doesn't *dry out* foods, preserves all the natural juices and tempting color of fried chicken, or meat loaf, or mashed potatoes . . . keeps hard rolls crisp, or soft rolls soft—several foods at one time, in one warmer. There's no installation cost and the smallest possible expense for current. Just plug it in, and TOASTMASTER Roll and Food Warmer is on the job for you . . . and for those you want to feed well.

Illustrated above is the popular 4-drawer model. Also made in 2, 3, and 5-drawer sizes with varying capacities, to fit every need.

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Toastmaster Products Division, Elgin, Ill. Manufacturers of "Toastmaster" trademarked fully automatic Toasters, Bun Toasters, Roll and Food Warmers, Waffle Bakers.

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Looking at Hospital Windows

DORIS DUNGAN
Executive Housekeeper, Hartford Hospital, Hartford, Conn.

Mrs. Dungan offers helpful suggestions regarding methods of dressing up the windows to remove that "institutional" look

THE homelike and reassuring atmosphere that is so important to patients in our hospitals is aided materially by the treatment given to the windows. Shades and venetian blinds, for example, with or without draperies and glass curtains, are used to tone or shut out light, to ensure privacy and to give decorative importance to the windows. They should be attractive in appearance and should harmonize with the color scheme and character of the room.

In spite of the increasing trend toward the use of venetian blinds, some hospitals may find them too expensive for use throughout the hospital; therefore, shades are still of great importance. The color of the shade should be sunfast and neutral. It should modify rather than shut out light and should blend with the other decorations. Cream, buff, light yellow, tan and green or a combination of colors, dark on one side and light on the other, are generally used. Dark or black shades are sometimes used in special places, such as operating rooms, to shut out light.

The material may be a good quality of cotton fabric, either white or dyed; linen; glazed chintz, or perhaps oilcloth. The three best known commercial shades are Holland, painted cloth and pyroxylin impregnated. These are made with a muslin or cambric foundation and are available in several qualities of finish and foundation. Holland cloth is made by filling the dyed cotton fabric with a heavy sizing mixture and pressing it between heavy rollers. Painted shades are made by applying a mixture of sizing and water color or oil paint to the cambric base, which is the usual foundation. A pyroxylin shade has a muslin base that has been impregnated with pyroxylin to make the fabric waterproof.

The material in shades of any kind should not be affected by exposure to air or sunlight. The dye or coating should not warp and the shade should roll easily and quietly. Any odor will, in all probability, disappear on exposure.

The proper way to clean window shades is to lay the shade on a flat surface and wash it with warm water, neutral soap and a soft bristled scrubbing brush. Wash the shade in sections, rinse it thoroughly with a sponge and clean water, then dry it completely with a cloth and hang it up full length to finish drying. It is important that it does not wrinkle.

The shade should completely cover the glass with no cracks at the sides or bottom. The length should be 12 inches greater than the height of the window. When buying shades the correct measurement must be designated, *i.e.* cloth measure, which is just the width of the shade itself; barrel measure, which is from one end of the roller to the other, or tip to tip measure, which is the width of the complete fixture.

Shades are mounted by attaching to either a wooden or a metal roller. If the roller is metal a special attachment must be used. One housekeeper, who makes her own shades, puts a hem at the top, then slips the roller inside the hem before tacking. This eliminates tearing the shade from the roller.

Too many people take hold of the shade itself, instead of using the pull in the center of the lower slat, thus tearing the shade with their finger nails. To prevent such accidents, a double hem can be used at the bottom of the shade.

Shades may be hung at the top of the sash, at the bottom and drawn up by a cord or in the center with the top pulling up and lower part pulling down. This necessitates the use of a double bracket, which should be rigid and strong or it will cause the shade to roll unevenly. Shades should always be hung so that they will not blow or interfere with ventilation.

In addition to being decorative, venetian blinds adequately control the passage of light, sunshine and air. Usually, they are made of basswood or cedar slats, which are light and strong and will not warp. The tapes must be of a fast color and should not stretch or shrink. It is possible now to get plastic tapes, which simplifies the cleaning problem.

Venetian blinds should operate smoothly and be easy to raise, lower or tilt in any position desired or else their function is greatly impaired. They may be obtained in a variety of colors, of which the natural and neutral tones, with colored tapes, are most popular.

In using draperies or glass curtains over the window shade or blind, the amount of light desired is the most important consideration. If a great deal of light is desired, tie-back draperies with glass curtains or just simple curtains of gauze or scrim with no draperies at all are recommended. For a more subdued light venetian blinds may be used with a heavier type of curtain or drapery.

Often it is necessary to change the shape of the windows so that they will be more in keeping with the room. A tall window should have horizontal lines, which venetian blinds will provide. A valance, also, will bring down height. For a wide window use vertical lines and bring the draperies straight to the floor.

If the window is against a wall, half a pair of draperies may be used,

while two narrow windows that are close together can be treated as one by using a valance. If there is a radiator beneath the window, run the curtains to the sill only or hang them on the face of the wall letting them fall to the floor, thus missing the radiator altogether. Deep silled windows or those with window seats may also be treated in this manner.

Over draperies should go to the floor whenever possible. The width of draperies should be the full width of the material; the length should be the distance from the curtain rod to the apron line or to the floor. If a hem at the bottom and a heading at the top are desired in making draperies, add 9 inches to the exact measurement for the double hem and heading with a sufficient allowance to match the pattern.

Round topped windows may have a valance to conform to the shape of the window or a straight valance may be used to conceal the roundness. The depth of the valance should be one seventh of the total length of the drapery. A shaped valance is made by applying the same material as the drapery, or a blending or contrasting fabric, to a foundation of plywood or buckram. A plain valance should be as wide as the measurement across the top of the window; a gathered valance should be one and a half times the measurement across the top of the window, and a pleated one should be twice the width of the window.

THE HOUSEKEEPER'S CORNER

• When it was decided to put the maids at Albany Hospital, Albany, N. Y., into uniform a meeting was held so that all opinions regarding color and style could be given a hearing.

Washability, durability, appearance and economy were taken into consideration. The uniform that was finally selected was a tan poplin with dark brown collar, cuffs and pockets; buttons reaching to the bottom of the uniform; short sleeves, and V-neck. The opening of the entire garment assures ease in pressing, and buttons are taken out before going to the wash. Each maid is allowed three uniforms—one on, one clean and one in the laundry. The laundering is free and, barring accidents, two clean uniforms a week are ample. In case of loss, the maid pays for a new uniform. This ensures care that might otherwise be overlooked.

The housemen are furnished with neat gray coats and they may have as many as are needed to keep clean. Both maids' uniforms and porters' coats are dispensed through the housekeeper so that an accurate account may be kept.

Comfortable shoes with low rubber heels are insisted upon. Tired feet cause more trouble and inefficiency than any other one thing. Mrs. Althea C. Berry, executive housekeeper, tells us that she is as careful to have arch trouble, corns or any painful foot ailment taken care of by the doctors as she is to report a broken bone or pneumonia.

• "Hotel Housekeeping Standards and Employe Schedules"* is a convenient and valuable little book for any housekeeper. It is small, 4 by 6¼ inches, and gives much information in compact form. It can easily be carried about by new employes while they are learning the routine of new jobs, and if it is consulted frequently by employes of long standing it will give them a method of checking their work.

The duties of all housekeeping employes, from the executive housekeeper to the trash man, are given in tabulated form, easy to read and easy to grasp. Each type of employe has a section devoted to his particular job, listing hours, lunch time, days off, uniform requirements, work required from hour to hour and special duties.

The lists of work requirements and special duties are worded so as to give a considerable amount of detail as to methods of procedure.

There are also sets of general rules, lists of supplies needed in guest rooms and elsewhere, linen inventories, supply room inventories and many other helpful hints for the hotel housekeeper. Many sections of the book are applicable to hospitals and will serve as a guide for hospital housekeepers in working out similar standards and schedules.—MILDRED L. BURT, *executive housekeeper, Mountainside Hospital, Montclair, N. J.*

• A trip to the hospital roof or lawn is good for mattresses and pillows. The problem is how to give them the benefits of sunshine and air with as little difficulty as possible. To accomplish this, Jane Peterson, executive housekeeper at Ancker Hospital, St. Paul, Minn., has devised racks for mattresses and pillows. These racks are light in weight and can be handled easily by one man.

They are made of wood and are divided into six compartments, both ends of which are open, with a 3 inch opening between the slats so that the mattress and pillow are completely exposed. Each compartment, too, is the length and the height of the mattress and pillow. Gliders beneath the legs permit the racks to be moved with little effort.

• An institute for executive housekeepers in hospitals of Minnesota and the Northwest was held January 2 to 4 at the University of Minnesota Center for Continuation Study. The institute was planned and directed by Stella Heinze, executive housekeeper of St. Barnabas Hospital, Minneapolis.

Such subjects as departmental organization; safeguarding employe health; identification and destruction of household vermin; wages and hours; housekeeping and nursing service; care and cleaning of rugs, fabrics and textiles, and linen control were discussed. One session was devoted entirely to the problems involved in cleaning various types of walls, flooring and woodwork.

"Faculty" members included Margaret B. McHugh, head of the maintenance and operation department of the University of Minnesota; Jane Peterson, Ancker Hospital, St. Paul; Ethel Schneider, Nicollet Hotel, Minneapolis; Marie Neher, executive housekeeper, University of Chicago Clinics, and Dr. Clement Clay, administrator of St. Barnabas Hospital.

Such enthusiasm was evidenced by the housekeepers who attended the institute that Miss Heinze hopes to expand it next year.

• It is important to maintain a careful check on the housekeeping of private patients' rooms to make sure that they are kept in "apple pie order," but it is the ward and semiprivate patients that Mrs. Wagner, the housekeeper at Princeton Hospital, Princeton, N. J., takes under her wing. They are the ones, she has discovered, who need a cheery "good morning."

As Mrs. Wagner puts it: "The few minutes you can spare to devote to these patients especially, to make them feel you really are interested, that you care whether they have a good night and that the pain is better, will prove time well invested. They appreciate every little attention you show them," she adds emphatically, "for many times they have real problems to face."

*By Ethel C. Schneider. Stamford, Conn.: The Dahls, 1940. Pp. 109. $1.

Savings With Full-Time Pharmacy

Expansion Program Cuts Costs

ADEQUATE but economical dispensing of drugs in the small hospital is an administrative problem of no mean proportions. In the Saginaw General Hospital, Saginaw, Mich., it had been the custom for many years to handle pharmaceuticals through a modified drug storeroom with the assistance of a part-time pharmacist. The latter feature had been considered a measure of economy inasmuch as a superficial consideration had indicated that the size of the institution and its pharmacy demands required no more.

Full-Time Pharmacy Justified

Recently, however, it was decided that a new pharmacy providing twice as much space and the full-time employment of the same pharmacist were justified in the interests of more efficient drug preparation and distribution and a more accurate control of drug charges. In spite of the fact that several more costly drugs have been introduced in the last five years the improved cost system has effected enough savings to defray much of the increased salary load.

When the pharmacist was in attendance only half a day, many individuals—usually members of the nursing staff—had access to the pharmacy. Adequate maintenance of stocks was difficult, if not impossible. Actually, the task became one of purchasing drugs when the container appeared to be empty. Frequently, small supplies were purchased at retail prices to fill in until direct buying could be done. Furthermore, the part-time pharmacist in this hospital was a part-time pharmacist elsewhere. He was making a valiant attempt to serve two masters. He was unable to assume a position of authority and responsibility in either place and thus never reached the degree of usefulness and efficiency of which he was capable.

Saginaw General Hospital is an institution of 130 beds. Three floors are occupied by patients. A fourth is devoted to operating rooms and the services related to them. On the ground floor are the kitchens, dining rooms, classrooms, x-ray department, laboratories and pharmacy. The pharmacy is now housed in three rooms, one of which is a compounding room, while a second serves as a dispensary. These quarters are close to the elevators and to the third room where large packages are received and stored. Adequate space permits the preparation of solutions and the compounding of formulas to an extent never before possible. In addition, it permits buying in larger quantities. For example, appreciable savings have been effected in such materials as vaseline, boric acid, magnesium sulphate and sodium chloride. Standard cough mixtures, which were formerly purchased, are now made up by the pharmacist.

Drugs Listed Alphabetically

The new quarters provide enough shelf space to allow all preparations to be arranged in sections of cabinets that are identified by letter and number; the section is marked by a letter and the shelf by a number. A loose-leaf notebook serves as a catalog. In this all preparations are listed alphabetically and followed by a letter and a number which direct the searcher to the product desired. This is a source of great satisfaction to the pharmacist and is of importance when he is relieved by someone else.

This department purchases all pharmaceuticals and most of the operating room supplies. Here they are ordered, received, checked and ultimately dispensed by one person.

Two features of the pharmacy service merit description not because of any novelty but because they have effected economy by encouraging wise purchasing and by plugging leaks through which drugs are lost because of a haphazard system.

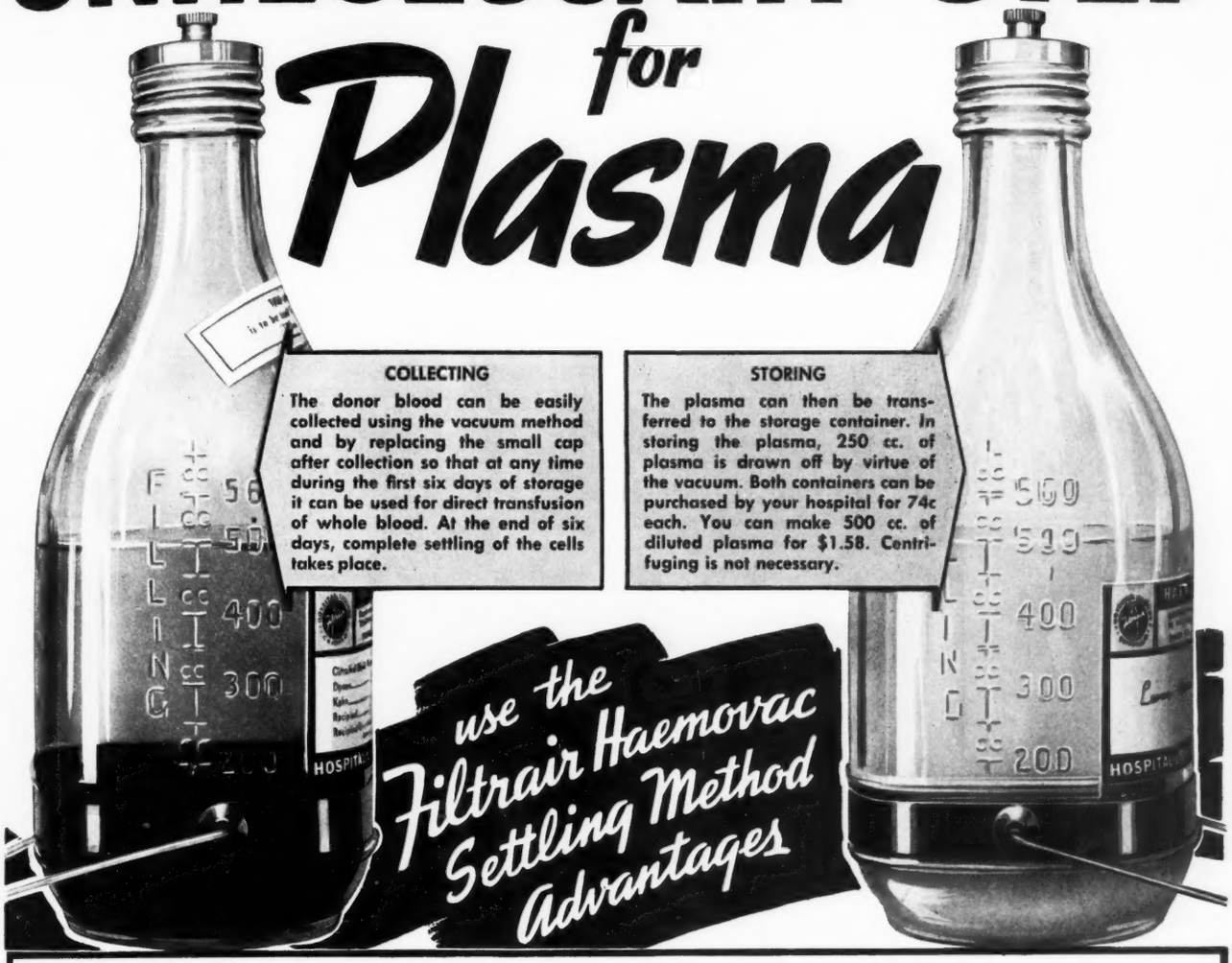
A purchase record book is kept. Every item purchased is entered with the date of order, date of delivery, name of manufacturer and cost. This is helpful in comparing prices but its greatest virtue lies in the fact that it becomes a quick means of determining how long a supply of a given drug lasts. In short, it is a basis for placing larger orders to take advantage of lower prices.

Emergency Stock on Each Floor

To make the service more efficient a stock of emergency preparations and commonly used drugs is maintained on each floor. The pharmacist has a definite inventory of this floor stock and sees to it that it is complete every morning. When a preparation is used the nurse places a charge slip on a spindle in the drug cabinet. Each morning these slips are sent to the pharmacy in the drug basket with any empty containers. The pharmacist merely replaces the preparations for which there are charge slips. An inspection of the floor stock at any time must reveal that the sum of the drugs and the charge slips equals the figure for the complete floor stock inventory. This simple procedure prevents confusion on the floor because of depletion of stock, saves time spent running to the pharmacy, assures proper charging of drugs and exposes any leak.

After replenishing the stock each morning the charge slips are sent to the office for bookkeeping purposes. The supervisor on each floor knows the inventory and quickly detects any discrepancy before sending to the pharmacy to replenish her stock. Preparations requiring charge slips are plainly marked to avoid confusion on the part of the inexperienced nurse or student nurse.

CUT OUT THIS UNNECESSARY STEP for Plasma


COLLECTING
The donor blood can be easily collected using the vacuum method and by replacing the small cap after collection so that at any time during the first six days of storage it can be used for direct transfusion of whole blood. At the end of six days, complete settling of the cells takes place.
STORING
The plasma can then be transferred to the storage container. In storing the plasma, 250 cc. of plasma is drawn off by virtue of the vacuum. Both containers can be purchased by your hospital for 74c each. You can make 500 cc. of diluted plasma for $1.58. Centrifuging is not necessary.
use the Filtrair Haemovac Settling Method Advantages

1. No necessity to centrifuge. Prominent workers find this type container best for settling thus avoiding breakage loss.
2. Keeps plasma from contamination by means of screw cap seal at point of needle entry.
3. Provides for collection of full 500 cc. of blood and allows ample room for citrate without overflowing.
4. Whole blood can be used up to outdating period and then converted to plasma that can be stored for six months.

For descriptive literature write to

HOSPITAL LIQUIDS

CHICAGO *Incorporated* NEW YORK

The narcotic permit allows us to maintain a small supply on each floor. In this instance 25 tablets of each preparation are sent to the floor upon the receipt of a list containing the names of 25 patients. This is the only stock that is allowed to become depleted on the floor before it is replenished. When this occurs at night or during hours in which the pharmacist is not in attendance, the drugs are obtained from the central nursing office where a similar supply is held in a locked cabinet.

NOTES AND ABSTRACTS

Conducted by Carl C. Pfeiffer, M.D., F. F. Yonkman, M.D., Arnold J. Lehman, M.D., and Harold Chase, M.D., Wayne University, Detroit.

Sympathetic Depression

In the average patient a nicety of balance exists between the two divisions of the autonomic nervous system, namely, the sympathetic and parasympathetic systems; they have been referred to since Dale's introduction of the terms as the adrenergic and cholinergic divisions, respectively. As the terms imply, one system responds to adrenalin or epinephrine and their chemical derivatives, whereas the other reacts to acetylcholine and other choline homologues.

Frequently, a state of imbalance prevails that gives rise to clinical symptomatology characteristic of such diseases as thyrotoxicosis, paroxysmal tachycardia, megacolon and hypertension. Visceral, as well as peripheral vascular, diseases may result from this autonomic imbalance in which one system predominates over the opposite system.

Numerous attempts have been made to rectify this imbalance by the introduction of various drugs and chemical agents. One of the oldest and most satisfactory remedies is belladonna with its atropine and atropine-like alkaloids. Its propensity for insulation against parasympathetic neural stimulation throughout the entire system affords relief from miosis, profuse salivation, bradycardia, visceral colic, nocturnal enuresis and profuse perspiration. Atropine is a real depressant of peripheral neural function of the cholinergic type.

Apocodeine

• Attempts to depress or paralyze the adrenergic system have gained only limited clinical success, however. Experimentally, several drugs have produced adequate depression warranting the anticipation that, subsequent to proper chemical manipulation of known depressants, successful clinical usage will follow. One of the earliest antiadrenergic agents to be employed is apocodeine, which is codeine minus one molecule of water. The mere fact that such a slight chemical alteration results in changing an excellent depressant of the cough reflex mechanism to a depressant of peripheral neural complexes, as demonstrated by Dixon in England in 1903, offers research workers a distinct hope of obtaining many desirable correctives in this field.

Ergotoxine

• Another sympathetic or adrenergic depressant is found in ergot, which in fluidextract form is commonly used after childbirth. Among many alkaloids and alkaloidal-like substances contained in ergot is a substance called ergotoxine. Dale, in England in 1905, demonstrated in animals that augmentary sympathetic nerves, such as those controlling arterial tone of the circulatory system, are paralyzed by a sufficient amount of ergotoxine. This was nicely revealed by the response to epinephrine (adrenalin). Whereas epinephrine always produced a rise in blood pressure before ergotoxine was administered, after ergotoxine was given it produced a fall in pressure. Electrical stimulation of the splanchnic constrictor nerves before and after the administration of ergotoxine produced effects similar to those elicited by epinephrine and ergotoxine. This was the basis for Dale's conclusion that vasoconstrictor nerves alone are paralyzed by ergotoxine, while vasodilators remain unaffected so as to respond to epinephrine, resulting in a decrease of tension.

Later, Rothlin working in Basle, Switzerland, in 1929, succeeded in paralyzing the splanchnic inhibitory nerves of the intestines of anesthetized cats, thus indicating that although ergotoxine shows a predilection for paralysis of augmentary sympathetic nerves, inhibitory sympathetic nerves may be depressed in sufficient dosage. Clinically, however, ergot principles do not seem to warrant serious consideration as yet, since extremely high toxic doses in unanesthetized dogs were found by us (1932) to be ineffective in paralyzing the sympathetic inhibitors of the intestines. Hence, the search has continued in many laboratories and clinics.

Dioxane Derivatives

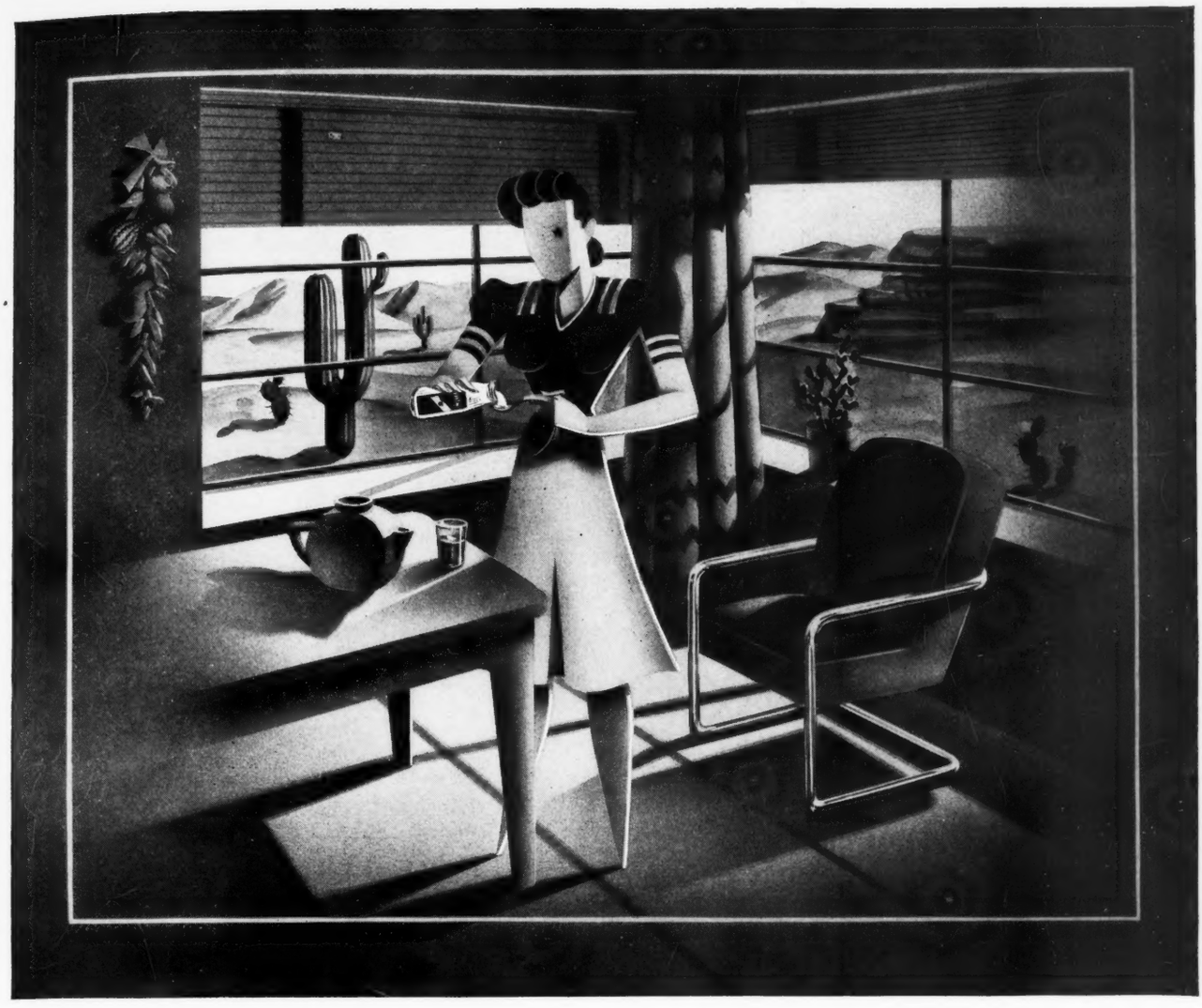
• French investigators, notably Forneau and Bovet (1933), have been interested in the antiadrenergic or sympatholytic properties of a new series of compounds called dioxane derivatives of phenol or phenol ethers. Melville, in Montreal, has also demonstrated that the dioxane compounds can reverse the effect on blood pressure in a way that is somewhat similar to ergotoxine. It is conceivable that among the various dioxane compounds one may be found which can be clinically tolerated with satisfactory sympatholytic action. Considerable research is still proceeding with these interesting chemicals.

Yohimbine

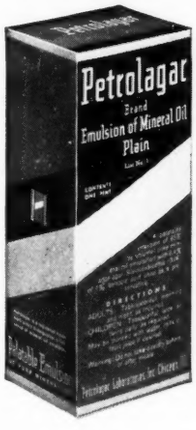
• One of the most interesting depressants of the adrenergic or sympathetic nervous system is yohimbine. This alkaloid was first isolated in 1896 by Spiegel from the bark of the yohimbé tree grown in West Africa. Known also as quebrachin, it has local anesthetic properties like cocaine, as well as a strong vasodilating action. For this reason, no doubt, it has long been promoted as an aphrodisiac with indifferent success.

It has been well shown by Raymond-Hamet, in France, and by Young and his co-workers at Boston University that this vasodilatation is due to a loss of constrictor tone through the sympatholytic action of yohimbine. This holds true for many compounds of yohimbine, such as ethyl, butyl, allyl and phenyl yohimbine HCl. Not only can blood pressure be lowered by yohimbine but the drug also nullifies the action of epinephrine in the intestine, iris, salivary glands and liver. Furthermore, toxicity studies indicate that certain yohimbine derivatives seem to be potentially promising from a clinical point of view.

Research now in progress in this department concerns yohimbine, dioxane and other compounds capable of antiadrenergic or sympatholytic properties. It is believed that, if this action can be found sufficiently strong in a chemical derivative which is practically nontoxic, one may justly entertain high hopes for the successful treatment of essential hypertension by "peripheral depression" rather than by "central depression" (barbiturates and sedatives), nitrites, renal extracts or surgical intervention. Likewise, rather than overstimulate the parasympathetic system to effect a neural, autonomic balance in the patient afflicted with exaggerated regional or generalized sympathetic tone, inhibition or release of the latter may be effected by a sympatholytic agent and, hence, may afford relief of conditions that are caused by excess adrenergic activity.—Frederick F. Yonkman, M.D.



Petrolagar*... *for the Treatment of Constipation*



● Petrolagar Plain, is a bland emulsion of high grade mineral oil. It helps to soften the feces and promotes the formation of an easily passed stool.

Petrolagar Plain helps maintain regular bowel movement without the use of harsh laxatives.

Suggested dosage:

Adults—Tablespoonful morning and night as required
Children—Teaspoonful once or twice daily as required

Petrolagar—The trademark of Petrolagar Laboratories, Inc., brand emulsion of mineral oil . . . Liquid petrolatum 65 cc. emulsified with 0.4 gm. agar in menstruum to make 100 cc.

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News in Review

A.M.A. Congress Urges Deferment of Military Service for Medical Students

Strong representations to the federal government regarding the need for deferment of military service by medical students, interns and residents were made by many speakers before the annual congress on medical education and hospitals of the American Medical Association in Chicago on February 17 and 18.

Col. Leonard S. Rowntree, chief of the medical division, Selective Service System, Washington, D. C., stated that C. A. Dykstra, director of selective service, believes that blanket deferment is illegal and, so far as the selective service organization is concerned, is impossible. The final decision must remain with the local boards where it has been placed by the law and the regulations, Colonel Rowntree declared.

Dr. Ray Lyman Wilbur, chairman of the Council on Medical Education and Hospitals, was one of several medical educators and prominent physicians who voiced a deep concern over the effect of the draft upon the future of the medical profession.

"If those in authority in this country are wise they will make provisions through legislation so that no medical student can be drafted or volunteer and so that those who are proposing to study medicine are given adequate trial before they are drafted into some other line of duty. After the first hospital year is completed then the young physician can be relieved for such military or civilian service as seems most appropriate for his qualifications or is most needed.

"It will be difficult to maintain the further training in the hospital that is required for those who are to be specialists, but provisions for this should be made and authority given to those who head our medical institutions to save from the waste of ordinary military service those who show special skill in either the laboratory or the clinic. It may be that the best procedure would be for them to be drafted and then sent back to the medical institutions or hospitals concerned."

Opportunities for Negro physicians to obtain internships have increased decidedly since 1927, according to Dr. Edward L. Turner, dean of Meharry Medical College, Nashville, Tenn. But, Doctor Turner stated, there are still few opportunities for Negro physicians to obtain residencies. He spoke appreciatively of the new refresher and other short courses being made available to Negro physicians.

ST. LOUIS IN 1942

At the midyear meeting of the trustees of the American Hospital Association it was decided that the 1942 convention will be held in St. Louis. Plans for the 1941 meeting in Atlantic City are nearing completion.

Red Cross Head Predicts Increased Use of Nurse Aids

An increased use of aids to supplement the work of well-trained nurses was predicted by Mary Beard, director of nursing of the American Red Cross, speaking before the annual meeting of the Central Council for Nursing Education in Chicago, February 17. She urged that good schools of nursing increase their enrollment by 14 per cent during the next year and that every effort be made to draw back into practice nurses who have retired but are still able to do nursing, even on a part-time basis.

Miss Beard urged particularly that the teaching quality in schools of nursing should not be lowered during the present crisis. She announced that the American Red Cross has been working for about a year on a plan for training aids in certain large cities and this is just ready to be launched.

New Hospital Association Formed

Hospital officials throughout Maryland and the District of Columbia have formed their own association to be known as the Maryland-District of Columbia Hospital Association. This organization is to affiliate eventually with the American Hospital Association and one of the sectional conferences. The following officers were elected: president, Dr. Winford H. Smith, Johns Hopkins Hospital; president-elect, Harvey Weiss, Memorial Hospital, Cumberland, Md.; first vice president, O. K. Fike, Doctors' Hospital, Washington, D. C.; second vice president, Dr. Clyde Frost, Union Memorial Hospital, Baltimore; secretary, E. Reid Caddy, South Baltimore General Hospital, Baltimore, and treasurer, Parker J. McMillan, Baltimore City Hospitals, Baltimore.

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RESEARCH TO IMPROVE TECHNIC, REDUCE COSTS

Officers of State and Regional Associations Hold Midwinter Meeting

Nearly 30 state hospital associations were represented at the midwinter meetings of the presidents, secretaries and legislative chairmen of state, provincial and regional hospital associations held in Chicago on February 15 and 16. It was an exceptionally large attendance and more than 100 persons were present for most of the sessions.

The conference heard reports of work in progress from the chairmen of the various councils of the A.H.A., discussed national defense and federal legislation, reported on legislation in the various states and considered the building of programs for state and regional meetings.

It was announced during the meetings that the A.H.A. had finished paying off the bonds on the headquarters office building which will make more money available for the conduct of the association's affairs.

The presidents and secretaries went on record in favor of old-age pensions for hospital employes and for deferment of military service for interns, residents and medical students. Pointing out that interns and residents are indispensable to hospital service and that scores of instances have been reported where these young physicians have been refused deferred status by local draft boards, the board of trustees petitioned the Council of National Defense to effect the issuance of an executive order to grant deferred status to interns, residents and undergraduate medical students until the completion of their training. This would prevent the unhappy results that will follow the present lack of a uniform policy on the part of the various draft boards.

At the suggestion of the health and medical committee of the Federal Security Agency the board also suggested that hospitals give a leave of absence for the period of their military service without change of status to nurses, radiologists and others in the service of the hospital who volunteer for military duty. The resolution urged that hospitals do this "if consistent with local conditions."

In view of the large demands for surgical and hospital supplies being made by the armed forces, the board of trustees noted that civilian hospitals are experiencing difficulty in obtaining deliveries of such vital items as catgut, kitchen utensils, rubber goods and drugs. It was voted to inform the Council of National Defense of the present danger to civilian health in this situation and urgently to request that civilian hospitals be given the same priority in the delivery of commodities required by them as is accorded to governmental agencies.

$12,000,000 Appropriation Asked for Nursing Education

A recommendation for an appropriation of $12,000,000 to finance nursing education has been made by the U. S. Office of Education, J. W. Studebaker, commissioner of education, announced recently.

Speaking at the banquet of the American Association of Teachers' Colleges in Atlantic City, N. J., Commissioner Studebaker asserted that 10,000 more nurses than are normally trained each year should be graduated from nursing schools this June to meet the needs of the defense program.

The speaker explained that it will be recommended that much of this money should be spent to finance refresher courses for graduate nurses who have retired from active nursing work. He warned that there will be a "bottleneck" unless many of these former nurses return to their profession and more are graduated.

The 300 heads of teachers' colleges were meeting in conjunction with the American Association of School Administrators, which held its annual convention at Atlantic City, February 23 to 28.

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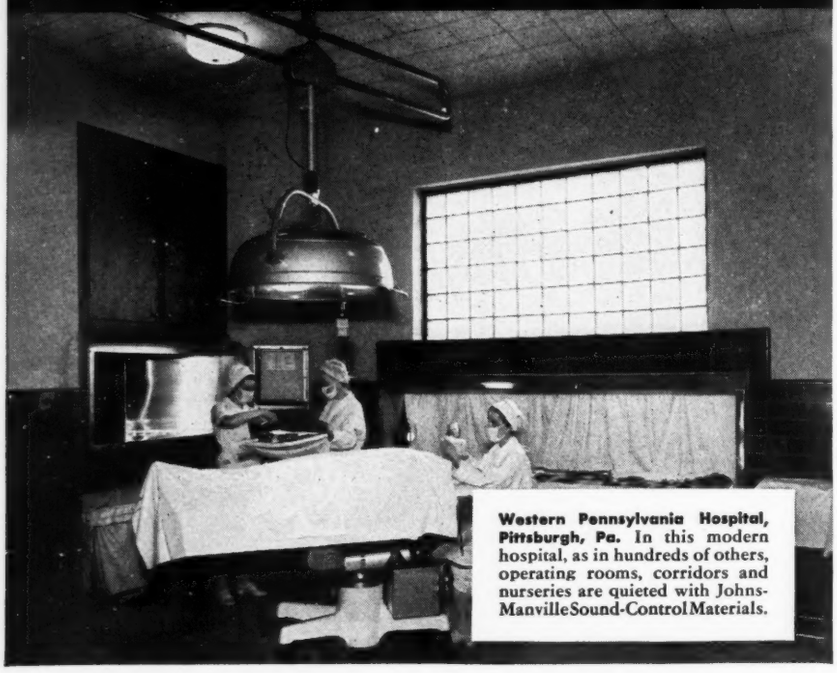

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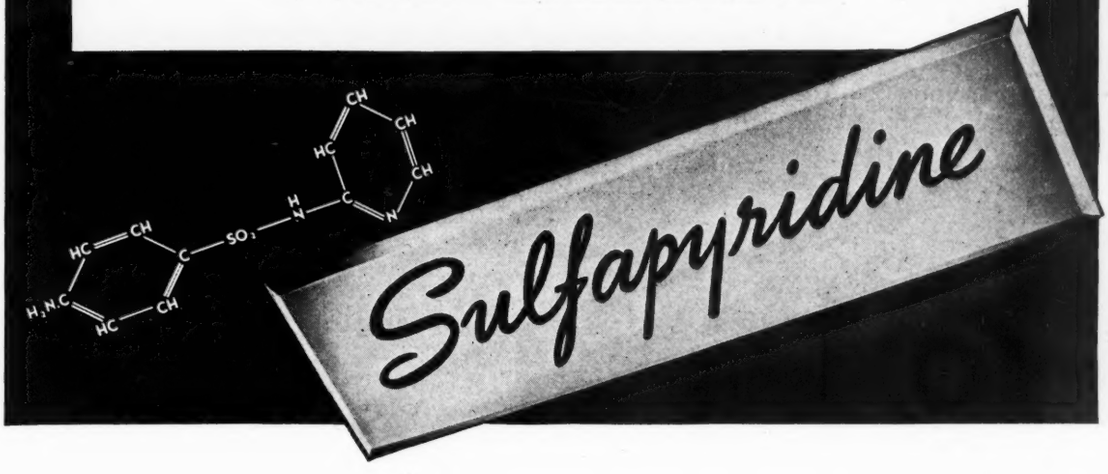

THIS year the physician has been able to view pneumonia with a degree of confidence that was impossible in the past. The striking therapeutic results obtained with sulfapyridine in pneumococcic pneumonia have profoundly altered the prognosis in this disease.

An analysis of more than 3,000 cases of typed pneumococcic pneumonia treated with sulfapyridine during the winter of 1938-39 showed the following case fatality rates:

Total No. of Cases	3,005
Gross Fatality	6.0%
No. of Bacteriemic Cases	240
Fatality	23.3%
No. of Non-bacteriemic Cases	2,765
Fatality	4.5%

During the pneumonia season of 1939-40 this clinical experience was duplicated in a large number of cases. A statistical review† of 9,162 cases revealed that the fatality rate in pneumonia patients treated with sulfapyridine was less than half that obtained with previous methods of treatment.

With wider dissemination of knowledge concerning this remarkable drug and its more widespread use, it is to be expected that the fatality rate from pneumococcic pneumonia throughout the nation will be reduced to a new low level during the current pneumonia season.

†Faller, C. P., Quickel, K. E., and Smith, C. W., Penn. M. J. 43:789-800, March, 1940

Council ACCEPTED AMERICAN MEDICAL ASSN. *Accepted*

Sulfapyridine is manufactured by Merck & Co. Inc. under license from the originators of the product, May & Baker, Ltd., of London. Supplies are available to the medical profession through their druggists under the labels of leading pharmaceutical manufacturers.

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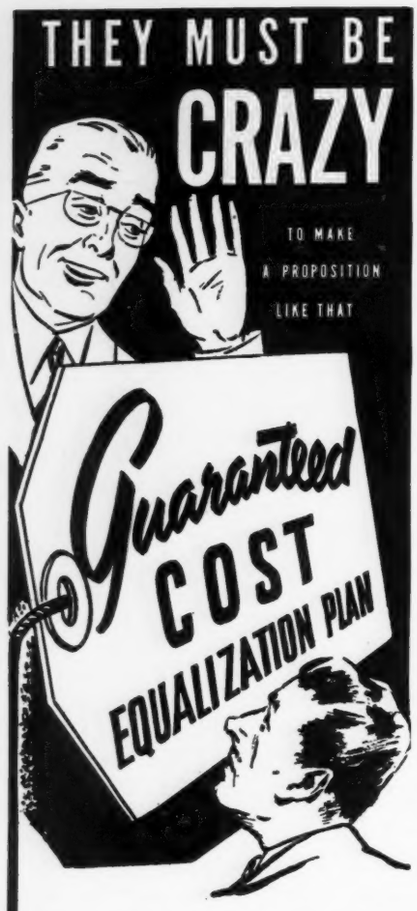

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More than that, we go so far as to say that Car-Na-Var and Car-Na-Lac will save you money in both time and labor costs as well.

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Labor Union Demands "Peace Conference" With Western Pennsylvania Hospital

A demand has been made by Local 255 of the State, County and Municipal Workers of America (C.I.O.) upon the Western Pennsylvania Hospital, Pittsburgh, for a conference to adjust "the differences existing between the management of the West Penn Hospital and its employes."

In his answer to the demand, M. H. Eichenlaub, superintendent, states that "we do not admit that there are any differences between the management of this hospital and its employes, other than, perhaps, those created or instigated by your organization" and that "our consistent policy has been to deal directly with our employes without the interference of labor unions; if some of our employes have joined your organization, they have not been denied, nor will they be, the same rights and privileges they have always had to meet with the management of this hospital at any time.

"Because of our distressing financial situation, the details of which are well known to you, we have not been able to offer wages and salaries comparable to those in private industry. This is a situation that is no more satisfactory to the directors and to the management than it is to our employes or to your organization. We are sincerely trying to do all we can, at all times, to improve the situation of our employes; the implied threat in your letter can cause us to do no more, or less, than we are doing.

"Our discussions with your organization in the past have not by any means convinced us that your organization recognized the interests of the public or of this institution. You may rest assured that in the interest of the public and especially that portion of it which is sick and injured and in our care we shall take active and energetic measures by all lawful means at our disposal to resist and suppress any attempts by your organization to create any disturbances in or about our hospital which would in the slightest degree interfere with the operations of the hospital."

Mr. Eichenlaub also reported to the members of the Pennsylvania Hospital Association that this union is planning to introduce legislation in the present session to bring hospital workers under the state labor relations act and to seek a legislative investigation of the finances and working conditions in state-aided hospitals with a view to the ultimate establishment of minimum wages and maximum hours.

Higher Payments for City Cases Urged

The Greater New York Hospital Association has decided to push its appeal to the city to increase the rates of payment to voluntary hospitals for the care of city cases. The association is also concerned over the medical requirements for admission of city cases to voluntary hospitals. At a recent meeting one speaker declared that it was not proper to approve a case only if the patient would die if he were not hospitalized.

C.H.A. to Meet June 16 to 20

The dates for the 1941 convention of the Catholic Hospital Association have been set for June 16 to 20, according to an announcement by the officers of the association. The meeting will be held at Convention Hall in Philadelphia.

Coming Meetings

March 3-6—Association of Western Hospitals, Fairmont Hotel, San Francisco.
March 4—Association of California Hospitals, San Francisco.
March 7—Alabama Hospital Association, Montgomery.
March 10-12—American College of Surgeons, Sectional Meeting, Hotel Nicollet, Minneapolis.
March 11—Massachusetts Hospital Association, Boston.
March 12-14—New England Hospital Assembly, Hotel Statler, Boston.
March 17-19—American College of Surgeons, Sectional Meeting, William Penn Hotel, Pittsburgh.
March 26-28—American College of Surgeons, Sectional Meeting, Utah Hotel, Salt Lake City, Utah.
April 3-4—Kentucky Hospital Association, Louisville.
April 7—Tennessee Hospital Association, Nashville.
April 16—Louisiana Hospital Association, New Orleans.
April 16-18—Hospital Association of Pennsylvania, Bellevue-Stratford Hotel, Philadelphia.
April 17-19—Southeastern Hospital Conference, New Orleans.
April 21-23—Iowa State Hospital Association, Fort Des Moines Hotel, Des Moines.
April 24-25—Mid-West Hospital Association, Kansas City.
April 24-26—Carolinas-Virginias Hospital Association, Greenville, S. C.
April 25-26—Washington State Hospital Association, Tacoma.
April 29-May 1—Ohio Hospital Association, Deshler-Wallick Hotel, Columbus.
May 7-9—Tri-State Hospital Assembly, Stevens Hotel, Chicago.
May 12—Mississippi State Hospital Association, Biloxi.
May 15-17—New Jersey Hospital Association, Atlantic City.
May 21-23—Hospital Association of the State of New York, New York City.
June 16-20—Catholic Hospital Association, Convention Hall, Philadelphia.
July 17-18—Mid-West Institute for Hospital Administrators, University of Colorado School of Medicine and Hospitals, Denver.
Aug. 17-19—National Hospital Association, Chicago.
Sept. 12-14—American Protestant Hospital Association, Atlantic City, N. J.
Sept. 13-15—American College of Hospital Administrators, Atlantic City, N. J.
Sept. 15-19—American Hospital Association, Atlantic City, N. J.
Oct. 14-17—American Public Health Association, Hotel Traymore, Atlantic City, N. J.
Oct. 23-24—Missouri Hospital Association, St. Louis.
Nov. 13-14—Kansas Hospital Association, Topeka.
Nov. 13-14—Oklahoma Hospital Association, Oklahoma City.
Dec. 4—Utah Hospital Association, Salt Lake City.

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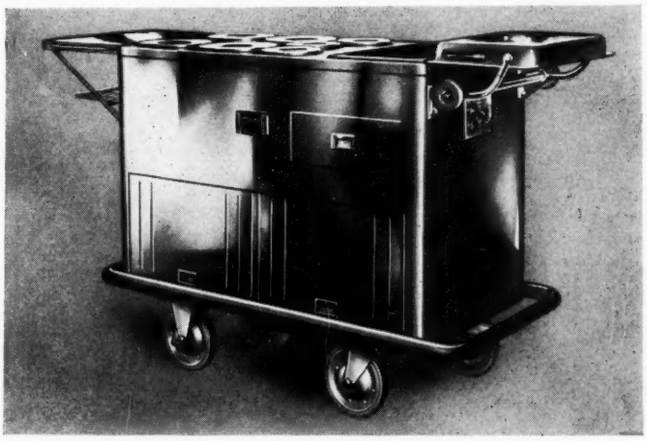

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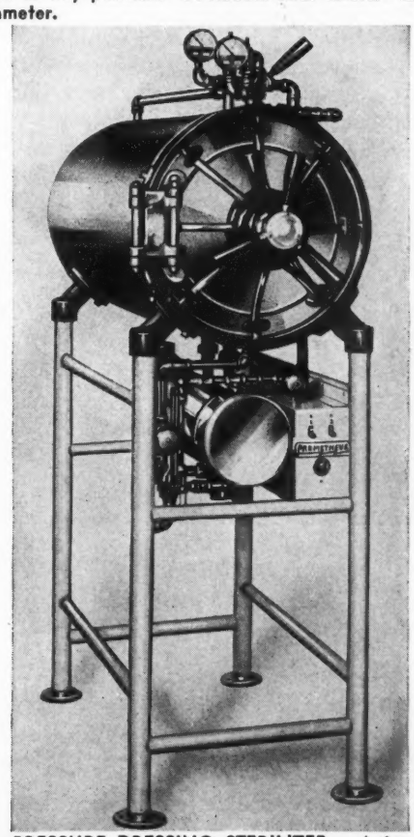

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Dental Program Discussed by Social Service Committee

"Dental programs for young men in the predraft age and for those likely soon to be called should be part of outpatient service."

This statement was made by Dr. J. A. Salzmann, director of dental service and of the School for Dental Technicians, Central School of Business and Arts of the New York City Department of Education, at a special meeting on dental care sponsored by the medical social service committee of the United Hospital Fund in New York City.

"Such programs should include fillings, artificial restorations and corrections of dental deformities," Doctor Salzmann told his audience, which was composed of chairmen and members of lay committees of the leading hospitals in New York.

Dr. John McCall, director of the Murry and Leonie Guggenheim Dental Clinic and chairman of the committee on community dental service of the New York Tuberculosis and Health Association, explained that the social service worker in the hospital sees dental service as a problem of oral rehabilitation and as a means for consolidating and preserving benefits gained in the hospital.

Also speaking from the standpoint of the medical social worker, Janet Thornton, director of the social service department, Presbyterian Hospital, explained that the medical social worker knows the serious effect of untreated dental conditions on the lives of men, women and children who are under the care of the hospital clinic.

A.H.A. Is Presented With Portrait of Monsignor Griffin

A handsome oil portrait of the Rt. Rev. Msgr. Maurice Francis Griffin, senior trustee of the American Hospital Association, was unveiled in the Bacon Library of the A.H.A. on February 15 in the presence of a large group of hospital officials who were in Chicago to attend the mid-winter hospital meetings. "Father" Griffin, as he is still generally known to the hospital field, has been a trustee of the association for twenty years.

The presentation address was made by Dr. Malcolm T. MacEachern, associate director of the American College of Surgeons, and the address of acceptance, by Dr. Benjamin W. Black, president of the A.H.A. In a humorous acknowledgment address, Monsignor Griffin warned the audience against taking his "obituaries" too seriously.

The portrait is a gift from an anonymous donor, whose identity was the subject of much speculation.

Travel Grants Given U. S. and Latin American Doctors

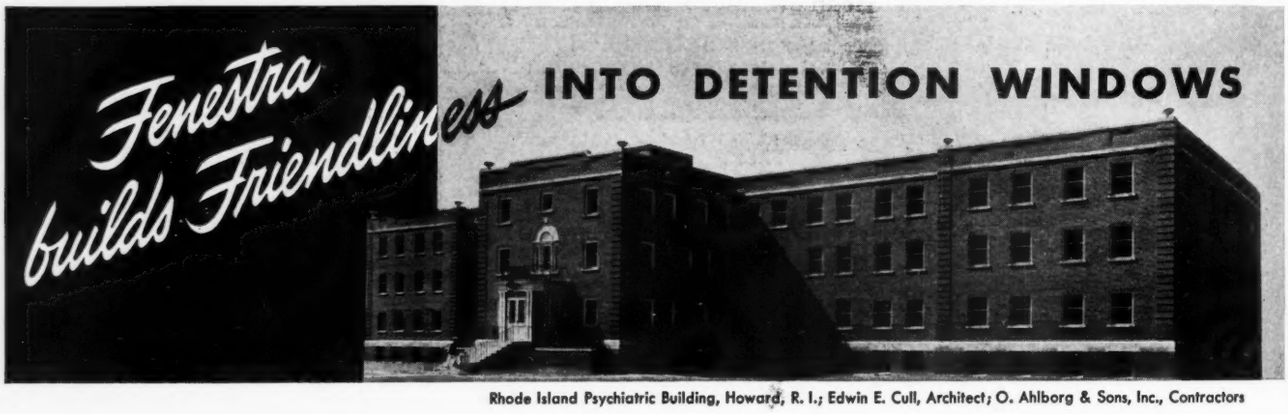
The interest of the U. S. Department of State in the development of cultural relations with Latin American countries, especially in the medical field, was exemplified in two acts last month.

Dr. Elmer L. Sevringhaus, president of the Association for the Study of Internal Secretions, and associate physician, Wisconsin General Hospital, Madison, was given a government travel grant to visit the Argentine and Uruguay to lecture before professional groups. He left the United States on February 20 and will return on March 23.

A delegation of six members of the faculty of medicine of the University of Habana also spent a week in New York City giving lectures and consulting with the Cornell University Medical College. The Habana and Cornell groups have been cooperating for the last two years in an annual exchange of undergraduate students and teaching personnel.

Twins Christen Maternity Unit

The arrival of twins christened the new maternity and children's building of Salem Hospital, Salem, Mass. Formal dedication ceremonies were held on February 8. The new building will add approximately 75 beds to the capacity of the institution.



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We have a special message for you who have prepared yourselves to serve in the medical and hospital fields. At a time like this, when medical organizations and hospitals are sustaining inroads in personnel, most of you who are not content with your professional status or location are keeping a weather-eye on the opportunities arising in your own communities. Yet, if the community is a large one, you may never hear of many openings which would have interested you strongly. If the community is small, you may never learn that in the town just ten or fifteen miles away is the opportunity you have always dreamed of finding.

The Medical Bureau with its national outlook can be of greater assistance to you, now, than ever before. When there are only a few positions available, it is a comparatively easy matter to decide which is most desirable. When there are countless opportunities for which you would be qualified, it is almost imperative that you have unprejudiced professional counsel as you make your decision.

If you will write us frankly about the work for which you are qualified and the type of connection you hope to secure, your correspondence will be held in utmost confidence, and we shall let you know immediately whether a position such as you seek may be obtained through our services. There are immediate openings for physicians who have specialized in the various branches of medicine, and for the physicians who have completed their training recently, for hospital administrators, graduate nurses, technicians, social workers and dietitians. May we tell you about them? Are you available for immediate appointment, or would you prefer a position beginning during the summer months, or next fall?

Write or telegraph for a registration form today, that we may help you, too, in gaining a broader outlook than ever before on opportunities present in your own field of endeavor.

Booth No. 33—Western Hospital Association—San Francisco—March 3-6

The MEDICAL BUREAU

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Value of Maintenance Defined by Commissioner of Internal Revenue

The question of reporting the value of maintenance for purposes of federal income tax has been clarified by a ruling from the commissioner of internal revenue which is referred to as IT-M Coll. No. 5023. The new rule is as follows:

"If a person receives as compensation for services rendered a salary and, in addition thereto, living quarters or meals, the value to such person of the quarters and meals so furnished constitutes income subject to tax. If, however, living quarters or meals are furnished to employes for the convenience of the employer, the value thereof need not be computed and added to the compensation otherwise received by the employes."

As a general rule, the test of "convenience of the employer" is satisfied, the bureau states, if living quarters or meals are furnished to an employe who is required to accept such quarters and meals in order to perform his duties properly. For example, if an employe is subject to immediate service at any time during the twenty-four hours of the day and, therefore, cannot obtain quarters or meals elsewhere without material interference with his duties, the value thereof need not be included.

Birth Rate Declines, Census Shows

Some time during the decade 1930 to 1940 birth rates and death rates in the United States changed so that the population of the United States no longer will maintain itself, according to data released last month by the Bureau of the Census. If present birth and death rates continue, the population of the country will fail to maintain its numbers by approximately 4 per cent per generation. In 1930 the birth and death rates meant that the population increased by 11 per cent per generation. The white population, on present rates, will decrease about 5 per cent per generation while the nonwhite population, according to these estimates, is increased at the rate of 7 per cent per generation.

Courses in Nursing Education

Five courses in nursing education will be offered at the summer session of the Colorado State College of Education, Greeley. These are offered in two four-week programs, June 16 to July 11 and July 14 to August 8. The nursing faculty includes Phoebe M. Kandel, professor of nursing education; Henrietta Adams, associate professor of nursing education, University of Washington, and Elizabeth Melby, associate professor of nursing education, Yale University.

Vonderlehr Reports Findings on Blood Tests of Draftees

"More than 5000 cases of syphilis have already been found among selective service candidates," R. A. Vonderlehr, assistant surgeon general of the U. S. Public Health Service, said at a regional conference on social hygiene and national defense in St. Louis last month.

He presented the findings of a preliminary tabulation of 120,000 blood tests and physical examinations for syphilis performed on selective service candidates in 23 states during November and December 1940.

Rates among the states range from 7 to 114 per thousand men examined, Doctor Vonderlehr reported.

"It will be noticed," the assistant surgeon general pointed out, "that the two groups of states with the highest average rates are composed of Southern states. Comparison shows that they also were among those states that had the highest syphilis rates for men drafted in the last World War."

Kansas Group Issues New Bulletin

Volume 1, number 1 of the Kansas State Hospital Association "Bulletin" was issued on February 1. The bulletin is designed to convey news of Kansas hospitals to the association members.

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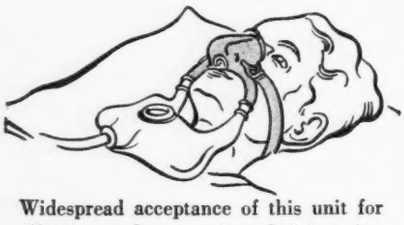

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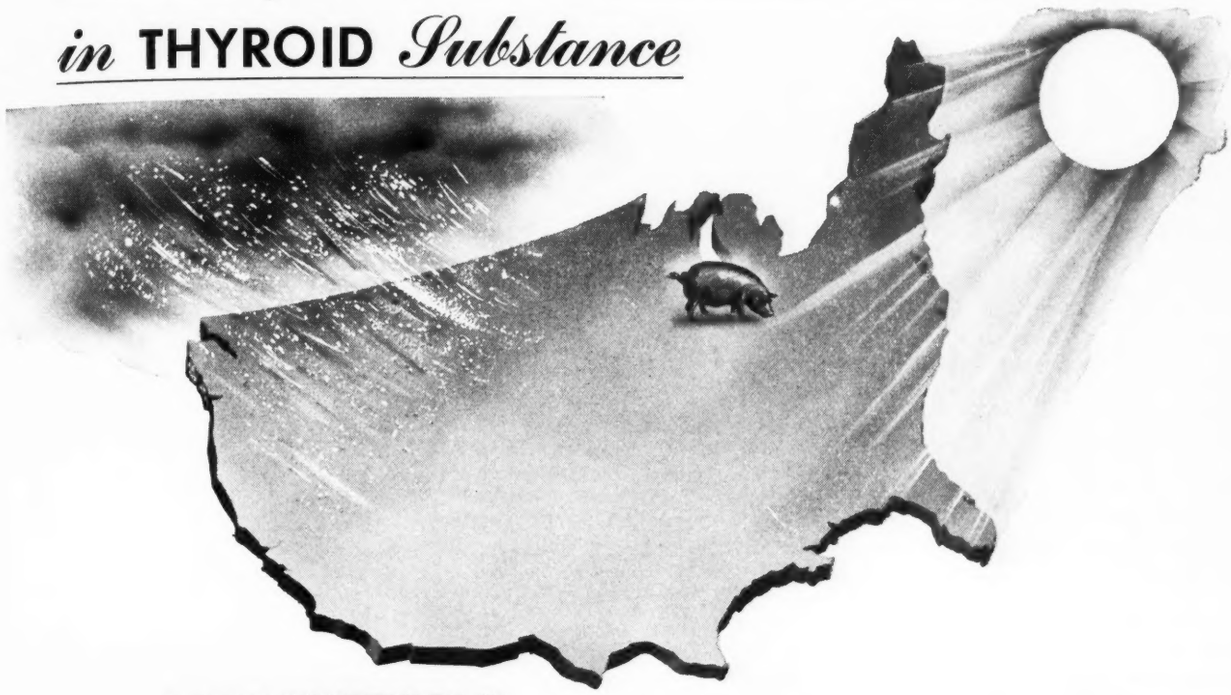


A BASIC UNCERTAINTY IN THYROID MEDICATION OVERCOME BY ARMOUR PIONEERING METHODS

Uniformity, and standardized unvarying potency are factors of fundamental importance in thyroid medication. Thus the seasonal and regional variations in the thyroid of animals has been a disturbing problem in the preparation of therapeutic thyroid tablets and powder. ARMOUR LABORATORIES, seeking ever greater perfection in their products, were quick to recognize these elements of uncertainty. They pioneered in devising and instituting methods for overcoming them.

In the preparation of THYROID in powder and tablets the Armour Laboratories today employ a technique of assaying and then blending desiccated animal thyroid, so as to compensate for the seasonal variation in the natural iodine store. In addition, the selected animal glands are carefully chosen by geographic areas, where a relatively stable proportion between the thyroxin and the other organic iodine compounds of these glands exists. Such methods of selection are possible to the ARMOUR LABORATORIES because of the large supply of natural raw material which they have available. But in addition, every step in the processing of THYROID ARMOUR is carried out and checked carefully by the most modern methods so as to make available a preparation of uniformly balanced potency throughout the year. Regardless of whether you are treating a case of cretinism, of obesity, of mild hypothyroidism, of dry itching skin, or any of the other manifold manifestations of thyroid hypofunction, it is sound practice to specify "THYROID ARMOUR", for behind this preparation is a 30-year history of technical knowledge and clinical effectiveness.

THYROID ARMOUR is supplied in 1/10, 1/4, 1/2, 1, 2 and 5 grain tablets, and in powder U. S. P. Your patients will find it available on your prescription at reputable pharmacies throughout the country.

The Armour Laboratories

MEDICINALS OF ANIMAL ORIGIN
CHICAGO • ILLINOIS

Victorian Institute for Hospital Administrators Organized in Australia

A Victorian Institute of Hospital Managers and Secretaries has been formed in Australia to carry on work similar to that of the American College of Hospital Administrators. The institute was incorporated last June and all eligible persons who applied before June 30 were accepted as foundation members. Subsequent applicants are required to pass examinations.

Close collaboration has been established with the Victoria Charities Board since parliament has decreed that all future appointments to managerial positions must be approved by the board.

The examinations are divided into two sections. The first section is covered by the passing of the intermediate examination of any recognized accountancy institute. This is designed to provide for a reasonable educational standard and a standard of accounting requisite for hospital administration. It does not require the extended knowledge in particular phases of accountancy provided by the final examinations of accountancy institutes.

The second section is to be a special qualifying examination covering all of the appropriate parts of hospital administration. A committee has been appointed to draw up this part of the examination. Another committee is studying the possibilities of a retirement pension plan for hospital executives.

New Building of Philadelphia Psychiatric Hospital Opened

The new Philadelphia Psychiatric Hospital, Philadelphia, a modern fireproof building erected on a five acre tract, was opened on January 17. The institution is to be devoted entirely to the psychiatric and neurological treatment of mental patients for whom there is hope of recovery.

The opening of the new building marked the completion of a successful experiment undertaken three years ago by a group of physicians and laymen who believed that a small hospital devoted to the treatment of apparently curable cases would help to reduce the population of public mental institutions. The first hospital was located in a remodeled mansion at Warrington, Pa. In its three years of operation 230 patients were treated with shock therapy.

The new hospital has an initial capacity of 60. It provides wards, semiprivate and private rooms, as well as laboratories and recreation solariums.

Pontiac and Greenwich Hospitals Complete Drives for New Building Funds

Two hospitals recently completed successful campaigns for funds. Pontiac General Hospital, Pontiac, Mich., reported a total of $105,000 contributed by voluntary subscriptions from members of the community during a six weeks' campaign. The money will be used to complete three floors of the existing building that had been left unfinished because of lack of funds. The additional space will add 77 beds to the institution's capacity. The funds will also make possible the furnishing of wards and rooms and the purchase of necessary equipment.

Greenwich Hospital, Greenwich, Conn., made the quota of $500,000 that had been set when Mrs. Henry W. Bagley of Greenwich offered to contribute $500,000 to a fund for a new hospital if the community would match it dollar for dollar.

Air Conditioning Units Given

James M. Jackson Memorial Hospital, Miami, Fla., has been presented with an air conditioning unit for the operating room and a portable unit for the use of postoperative patients. The gift was made by Mrs. John Seybold of Miami.

HOW PRESBYTERIAN HOSPITAL

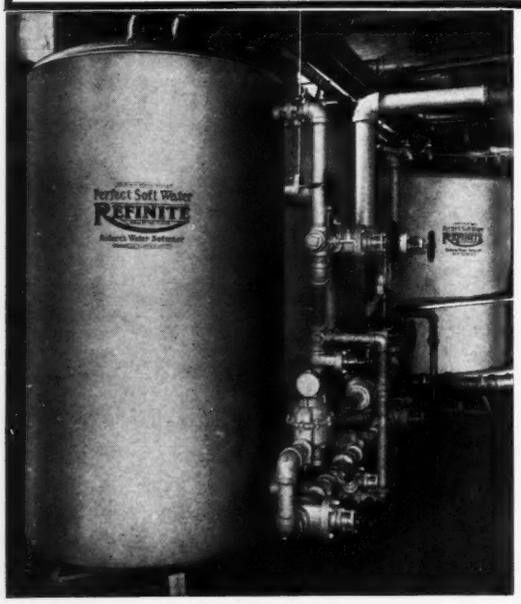
CUT OPERATING COSTS

WITH REFINITE WATER SOFTENING EQUIPMENT

★

A comprehensive article in the February issue of The MODERN HOSPITAL outlined the savings that a REFINITE WATER SOFTENER made possible in Presbyterian Hospital, Chicago. Read it for details.

★



• In June, 1939, Presbyterian Hospital, of Chicago, installed the REFINITE WATER SOFTENER illustrated at left. At the end of one year, hospital officials found that REFINITE had saved $1.430.82 in soaps and powders. In that same year, it saved $607.89 in housekeeping and dietary supplies, it saved $350.00 in boiler compounds and acids, plus approximately $400.00 in labor costs. In addition, REFINITE Soft Water cut washing time by almost 25%—from 69 to 52 minutes—assured longer life for linens, and used less water for rinsing.

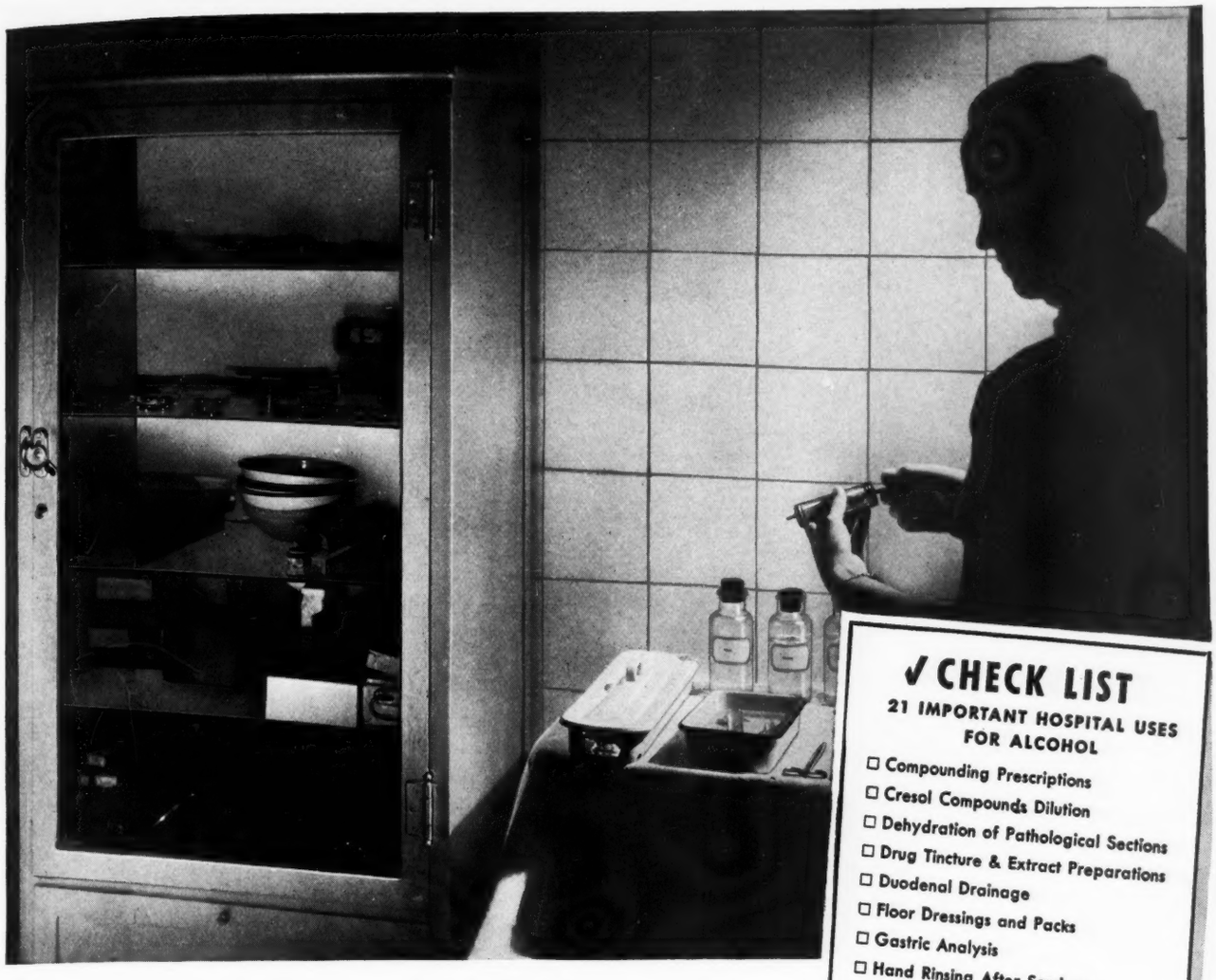
What REFINITE equipment has done for Presbyterian Hospital, it can do for YOUR institution. *You can save 40% to 70%* of your wash room supply costs, eliminate boiler compounds entirely —with REFINITE water softening equipment. Write for details.

THE REFINITE CORP.

RIVAL OF THE CLOUDS

REFINITE BLDG. OMAHA, NEBR.

Knife blades, scissors and other sharp instruments are sterilized by immersion in 70% alcohol for one-half hour.



✓ CHECK LIST

21 IMPORTANT HOSPITAL USES FOR ALCOHOL

- ☐ Compounding Prescriptions
- ☐ Cresol Compounds Dilution
- ☐ Dehydration of Pathological Sections
- ☐ Drug Tincture & Extract Preparations
- ☐ Duodenal Drainage
- ☐ Floor Dressings and Packs
- ☐ Gastric Analysis
- ☐ Hand Rinsing After Scrub-up
- ☐ Hypodermic Injections
- ☐ Massage and Sponge
- ☐ Pharmaceutical Preparations
- ☐ Pharmacy Solvent for Vegetable Drugs
- ☐ Preserving Specimens
- ☐ Protein Precipitant
- ☐ Spirit Lamps
- ☐ Stains and Reagents
- ☑ Sterilizing Instruments
- ☐ Sterilizing Skin
- ☐ Surgical Soap Preparation
- ☐ Sutures Sterile Solution
- ☐ Therapeutic Nerve Block

Because U. S. I. Pure Alcohol Exceeds U. S. P. Standards, It Is Better Suited For

STERILIZING INSTRUMENTS

STERILIZING of hospital instruments calls for the most painstaking care—and the purity of the alcohol you use is an essential factor in the effectiveness of your sterilizing technique. Safeguard your instruments by specifying U.S.I. Alcohol.

U.S.I.'s rigid standards of manufacture and testing result in the production of alcohol that is ideally suited for sterilizing instruments, because it equals —and even *exceeds*—the requirements of the U.S.P. U.S.I. Alcohol is tested not only by the methods of U.S.P. XI and N.F. VI, but also by additional methods developed by U.S.I. to assure an even higher quality—to meet all the needs of operating room, laboratory, or pharmacy.

You can benefit by the quality of U.S.I. Alcohol —and by the assistance of the U.S.I. representative in selecting alcohol for hospital use.

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Announce Programs for Sectional Meetings of the College of Surgeons

All sectional meetings of the American College of Surgeons will be held in March this year. In connection with each of the three day meetings a hospital conference is scheduled. Hospital sessions will include general discussions, panel round table conferences, question and answer meetings, scientific exhibits, motion pictures and demonstrations in the local hospitals.

The meetings will be held in the following cities: Minneapolis, Hotel Nicollet, March 10 to 12; Pittsburgh, William Penn Hotel, March 17 to 19, and Salt Lake City, Utah, Hotel Utah, March 26 to 28.

The opening session of each hospital conference will be devoted to a round table on "The Small Community Hospital: Its Special Problems." Outstanding leaders in hospital work will address the sessions of the hospital conference and will also participate in the various group discussions.

Hospital officials are invited to attend the concluding session of the sectional meeting in each city. These will be public meetings on conservation of health, with prominent surgeons as speakers.

Course in Hospital Food Service

A course in institution management for dietitians will be given at Teachers College, Columbia University, from July 2 through August 15. The course is being sponsored by Montefiore Hospital, Presbyterian Hospital and the United States Marine Hospital. Students will be afforded the opportunity to study procedures in the management of hospital food service. The course carries credits that can be applied toward a master's degree. Application for appointment to the course should be made to Dr. Mary deGarmo Bryan, Teachers College, before May 1.

Chicago N.E.H.A. Elects Officers

Mrs. Alta M. La Belle, housekeeping director of Michael Reese Hospital, Chicago, was elected president of the reorganized Chicago chapter of the National Executive Housekeepers' Association at a meeting held at the Stevens Hotel, January 28. Other officers elected include, Mrs. Bernice Nelson, Presbyterian Hospital, vice president; Mrs. Kay Donnelly, recording secretary; Mrs. Clare M. Gast, corresponding secretary, and Mrs. Mildred Page, Henrotin Hospital, Chicago, treasurer. Mrs. Marion Wyatt, a member of the national board, presented the chapter's new charter at this meeting on behalf of the national board.

Eastern Hospitals Ban Visitors During Epidemic

Several Eastern hospitals put a ban on visiting during the recent epidemic of influenza that swept the East Coast. Perth Amboy General Hospital, Perth Amboy, N. J., reduced visiting hours from four to two hours a day and ruled that only relatives were to be admitted.

Five hospitals in Albany, N. Y., agreed to a recommendation made by the Hospital Council of Albany to curtail visiting privileges. At Albany Hospital, besides limiting visitors to members of patients' families, it was decided that children under 14 years of age should not be admitted under any circumstances. In addition, the staff was authorized to watch the visitors and request those who obviously had colds not to enter.

Salem Hospital, Salem, Mass., quarantined itself for three days during the height of the epidemic and only husbands or wives of patients were admitted.

Grant Hospital Gives Benefit

The Chicago première of Walt Disney's new motion picture, "Fantasia," with Leopold Stokowski and the Philadelphia Symphony Orchestra providing the music, was a benefit for the women's auxiliary of Grant Hospital, Chicago. The performance netted the hospital approximately $3500.

COMFORT THAT FITS

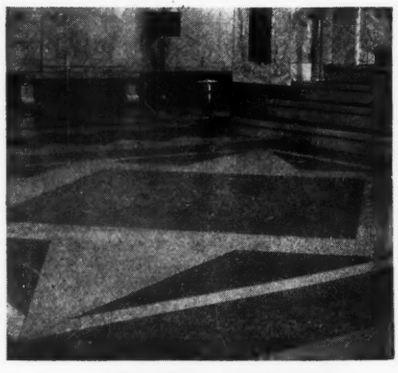
Automatic adjustment to body weight and position is but one of the Vital Values that have made the Spring-Air Mattress preferred by the progressive modern hospital. Get all the facts about all four of Spring-Air's Vital Values.

SPRING-AIR COMPANY, HOLLAND, MICHIGAN

How A Few Minutes Work May—

PRESERVE "NEW" LOOK IN TERRAZZO FLOORS Years Longer!

Adco developed Azzo-Seal to do this thing for you. It's not a varnish—not like anything you've ever used to seal terrazzo before. Doesn't darken or change the original surface color. But it resists water, acid, and alkali and gives your terrazzo floors a protecting seal that defies water or alkali to powder, chip or pit it.



Even if your floors aren't new, seal them now with Azzo-Seal. It dries n 30 minutes and preserves the new appearance of new terrazzo, brings a new luster and life to floorings that have been down for years.

TRY THIS NOW! Get a quart of Azzo-Seal! See how far it goes! How it improves terrazzo's appearance. This quart sent free to show you what Azzo-Seal can do for your entire terrazzo floor area. Write for it today!

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The Standard Console Control, designed for use with the Standard "Flexray" Deep Therapy X-Ray Unit, is a radical change in design from the controls used by all x-ray manufacturers for many years. The console control offers many advantages in addition to its attractive appearance.

For over thirty years the Standard X-Ray Company has devoted its entire efforts to the design and manufacture of superior apparatus. We are conversant with the requirements of the x-ray department in hospitals of all capacities, and offer you the benefit of our vast experience.

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Hospital Library Training Is Offered at Minnesota

The course in hospital library work, which has been included in the curriculum of the division of library instruction at the University of Minnesota since 1937, will be repeated during the spring quarter, from April to June. The training includes four courses: administration, book selection, reading and the mental patient and medical reference. In addition, there is an internship of six weeks.

At least three years' approved college work and two quarters in an approved library school or a full equivalent of approved experience in hospital library work are prerequisites to the course.

Applicants should write to Frank K. Walter, University of Minnesota Library, Minneapolis; Perrie Jones, St. Paul Public Library, St. Paul, or the registrar, University of Minnesota.

$45,000 Given Kansas Hospital

An outright gift of $45,000 has been presented to the Hays Protestant Hospital, Hays, Kan., for the erection of an addition to the hospital. Work on the building will start about April 1. It will be a two story brick and concrete structure and will increase the institution's capacity to 68 beds.

Technologists Move Headquarters

The registry of medical technologists of the American Society of Clinical Pathologists has been moved from Denver to Muncie, Ind., it was announced recently. The decision to move the registry followed the resignation of Dr. Philip Hillkowitz as chairman of the board of registry. Dr. Lall G. Montgomery, pathologist of Ball Memorial Hospital, Muncie, has been named as successor to Doctor Hillkowitz.

Seek Donations of Medical Supplies

The Medical and Surgical Supply Committee of America, an organization of physicians and surgeons with headquarters at 420 Lexington Avenue, New York City, is seeking donations of medicines and surgical instruments for shipment to England. Hospitals are being asked to contribute such materials as they can spare to help relieve the shortage that exists in English hospitals.

Nursing Institute at Chicago

An institute in nursing education for administrators, teachers and supervisors of nursing will be held at Judson Court on the University of Chicago campus, June 26 to 28. The central theme will be "Recent Developments and the New Outlook in Nursing Education."

A.S.T.A. Indicted by Government

The American Surgical Trade Association has been indicted for violation of the federal anti-trust laws on the ground that its plan of registering articles produced by members of the association constitutes monopoly. In reply to the charges, association officials asserted that the registration plan was devised only to stimulate production of new articles; that staple articles were not registered; that probably not more than 1/100 of 1 per cent of total sales in the surgical trade were registered articles, and that the use of the plan during the years it was in existence lessened rather than increased among the members of the association.

Classes for Male Nurses

A three months' course in theoretical nursing is being offered by the adult education program of W.P.A. in New York City to male pupils 20 years of age or older. The course was established to offset the shortage of male nurses in New York and in anticipation of the new state law which requires all practical nurses to be licensed. At the completion of the preliminary course, students will be examined to determine their eligibility to continue to receive instruction in a six months' course conducted by the Department of Hospitals.

A Sturdy Fella!

—and so is this

"Standard" SERVICE SINK!

IT'S BUILT to resist consistent hard use in Hospital Utility Rooms. It's the durable and efficient "Standard" Service Sink shown here.

It's constructed of rugged cast iron, finished in acid resisting enamel and it has an unbreakable chromium plated brass rim. Even with long constant service its good appearance lasts. It will provide years of satisfactory service.

Plus this, the "Standard" Service Sink has a strong, even flush for greater efficiency in waste disposal. The flush control valve is high, out of the way, equipped with vacuum breaker. The ample volume supply spout has bucket hook for added convenience.

24" x 20" in size, the "Standard" Service Sink has a trap for easy connection to floor or wall—it's perfect for modernizing your Utility Room.

Also available is a large variety of "Standard" enameled Service Sinks without flushing rim, with or without backs. Write today for catalogue.

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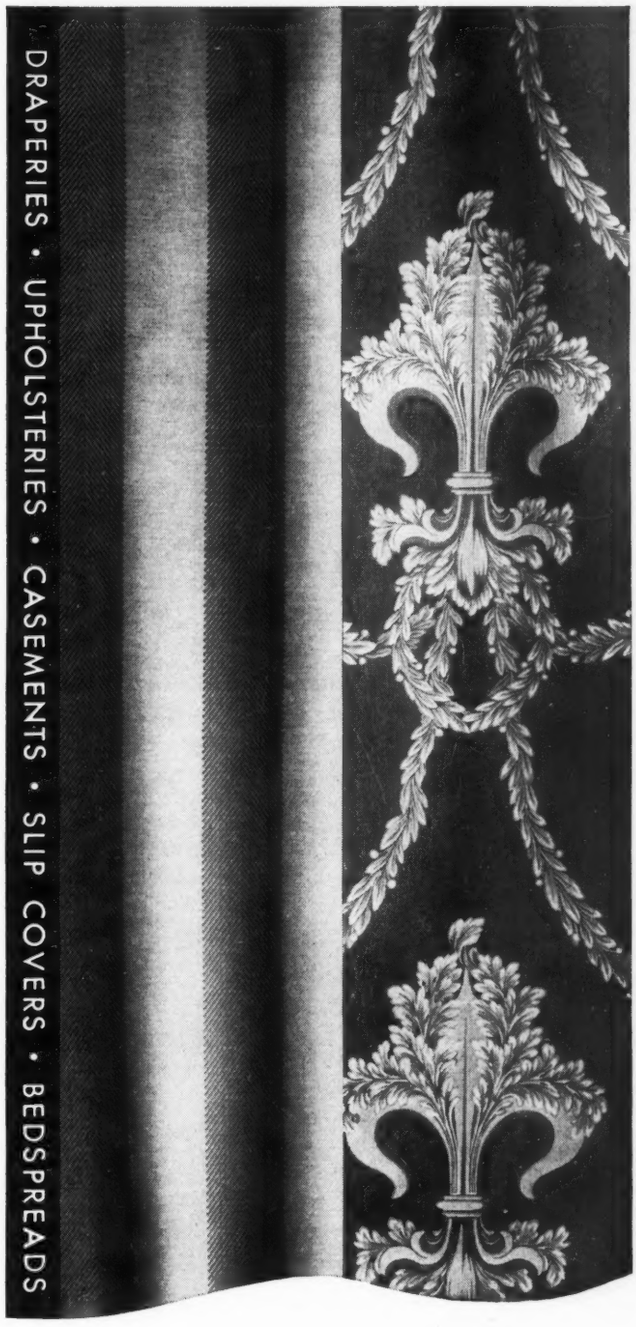
When your rooms need doing or re-doing quickly, you want to get straight to the point of manufacture. And that's here, at the new Goodall Fabrics showrooms, where a direct wire to the mill flashes your decorator or dealer's order quicker than you can say *"Woven with Mohair"!*

Goodall Fabrics have been doing a specialized hospital job for years . . . shaving upkeep, keeping up appearances. As one hospital executive said, "They've certainly cut down my trouble-turnover."

Drop in at our new showrooms when you're in New York . . . or drop the coupon below in the mail to get samples of Goodall's magnificent new woven-with-mohair fabrics. A swatch in your hand is worth a dozen in print!



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Names in the News

Administrators

Mrs. Mary J. Taylor, superintendent of Wilson Memorial Hospital, Sidney, Ohio, has resigned that position to accept the superintendency of Marion City Hospital, Marion, Ohio. Mrs. Taylor has been associated with Wilson Memorial Hospital for three and a half years. She succeeds Mrs. Margaret R. Parker, who died on January 12.

Lillian Williams recently tendered her resignation as head of Laconia Hospital, Laconia, N. H. She will remain until her successor has been chosen.

Margaret Watson, superintendent of Benedict Memorial Hospital, Ballston Spa, N. Y., has submitted her resignation to take effect on March 1.

Earl F. Mitchell, who has been head of Tompkins County Memorial Hospital, Ithaca, N. Y., since 1935, resigned January 20. Rosemary Chrystal will serve as acting superintendent until Mr. Mitchell's successor is appointed.

Arthur B. Solon has been appointed superintendent of Mount Vernon Hospital, Mount Vernon, N. Y., filling the post left vacant by Mary A. Land. Mr. Solon was formerly assistant superintendent of Wisconsin General Hospital, Madison, Wis.

James McNee, superintendent of St. Luke's Hospital, Duluth, was elected president of the Minnesota Hospital Service Association at the annual meeting of the board of directors. Other officers are E. M. Hauge, superintendent of Fairview Hospital, Minneapolis, vice president, and Dr. Peter Ward, administrator, Charles T. Miller Hospital, St. Paul, secretary.

Mrs. Alma Houston, for the last three and a half years superintendent of Dickson Memorial Hospital, Paragould, Ark., has resigned to accept the superintendency of the new Presnell Hospital now under construction at Kennett, Mo.

Dr. George A. Sherman, superintendent of Oakland County Tuberculosis Sanatorium, Pontiac, Mich., has been appointed head of the newly formed tuberculosis division of the state health department. He will have charge of the inspection of all state tuberculosis institutions.

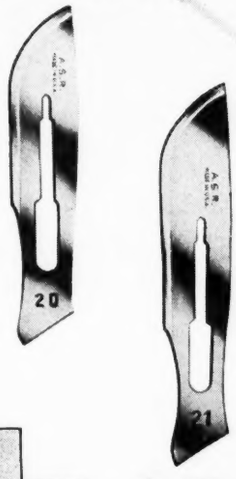
Dr. Herman J. Nimitz has been named to succeed Dr. Ernest E. Bishop as superintendent and associate medical director of Hamilton County Tuberculosis Sanatorium, Cincinnati. Doctor Nimitz is the former head of the Hamilton County Anti-Tuberculosis League. Doctor Bishop was transferred to the post of tuberculosis coordinator on February 1.

Mary Margerum, superintendent of Calumet Public Hospital, Laurium, Mich., has left that position to become acting head of Ossining Hospital, Ossining, N. Y. Jennie Hart Sullivan, former superintendent of Bound Brook Hospital, Bound Brook, N. J., had been selected for the post but notified the hospital officials that she would be unable to accept the appointment.

Harold M. Salkind, superintendent of Beth Abraham Home for Incurables, New York City, will assume the duties of executive director of Beth David Hospital, New York, on March 15.

Mrs. Esther Rogers Anderson, superintendent of Douglas County Jarman Hospital, Tuscola, Ill., resigned on February 1. Mrs. Anderson had been head of the institution since October 1935. Mrs. J. M. Fuller will serve as acting superintendent.

"These are the Uniform Surgeon's Blades the Doctor Trusts . . ."



"He says he's at his best with A. S. R. Surgeon's Blades—*and he is*, because he has every confidence in them. The edges of these superior, painstakingly inspected blades are unfailing in their uniformity. They have the correct degree of keenness." Why not check the blades now used in your operating room to determine if they meet this standard? If they do not, write us for samples, prices and full details.

Available in 9 sizes to fit all surgical handles.

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SURGEON'S BLADES *and Handles*

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Dr. Everett Morris, superintendent and medical director of Wish-i-ah Sanatorium, Auberry, Calif., filed his resignation with the Fresno County board of supervisors to take effect shortly after March 15. Doctor Morris has been medical director of the institution since its opening on May 16, 1929.

Mae Hindman has been appointed superintendent of Children's Hospital, Los Angeles, to succeed L. V. Swift. Miss Swift is retiring after twenty-six years as head of the institution.

F. E. Kassner, assistant director and comptroller of Michael Reese Hospital, Chicago, has been appointed associate director to succeed Albert H. Scheidt. Mr. Kassner has been associated with the hospital for eleven years.

Frederick J. Mocker, formerly executive secretary of the north side branch of the Y.M.C.A. of St. Louis, has been made assistant administrator of Evangelical Deaconess Home and Hospital, St. Louis.

Regina H. Kaplan, superintendent of Leo N. Levi Memorial Hospital, Hot Springs, Ark., was honored at a silver jubilee dinner given by the board of trustees to celebrate her twenty-five years of service to the hospital.

Department Heads

Pauline E. Davis, instructor in basic sciences and psychology at Grant Hospital, Chicago, has resigned that position to become director of nursing at Children's Mercy Hospital, Kansas City, Mo.

Deaths

Dr. Mary Swartz Rose, professor of nutrition at Teachers College, Columbia University, died recently at her home in New Jersey. Doctor Rose, a member of the Teachers College faculty for thirty-five years, was a leading authority in the field of nutrition and the author of many books on dietetics which are included in the bookshelf of every dietitian and cafeteria manager.

Dr. Charles Dennis Mitchell, for twenty-two years head of Mississippi State Hospital, Whitfield, Miss., died January 25 after a prolonged illness. Dr. Clyde M. Speck, assistant superintendent of the institution, has been serving as acting superintendent during Doctor Mitchell's illness. He has been designated by Governor Paul Johnson to succeed Doctor Mitchell.

Dr. George E. Vincent, former president of the Rockefeller Foundation, died February 2 at the age of 76. Doctor Vincent was one of the leading relief directors during the last war and directed the establishment of hospitals for the wounded both here and abroad. In May 1935 he was appointed chairman of a committee to direct a survey of the hospitals of New York.

Miscellaneous

Edwin A. Salmon, architect and consultant on institutional planning and commissioner of city planning of New York, has been appointed a member of the board of managers of Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York City.

William C. Conley has been appointed comptroller of Michigan Hospital Service, Detroit. Mr. Conley has been associated with the state insurance department of Michigan since 1933 in the capacity of examiner, and during the last two years has served as deputy insurance commissioner.

Lay Cornerstone of New Building

The cornerstone of the new five story addition to Englewood Hospital, Chicago, was laid Sunday, February 16. About 500 persons attended the dedication ceremonies at which Dr. B. W. Black, president of the American Hospital Association, was the principal speaker.

For Convalescent Comfort
. . . a soft, warm KENWOOD THROW
It's a mark of home-like hospitality for out-of-bed hours—a compliment that patients do not forget. Light in weight, yet sturdy and warm, this good-looking basket weave Throw costs little, lasts long. Four practical colors, hemmed ends.
Send for swatches and prices on Kenwood Throws and other Kenwood Blankets made especially for hospital use.
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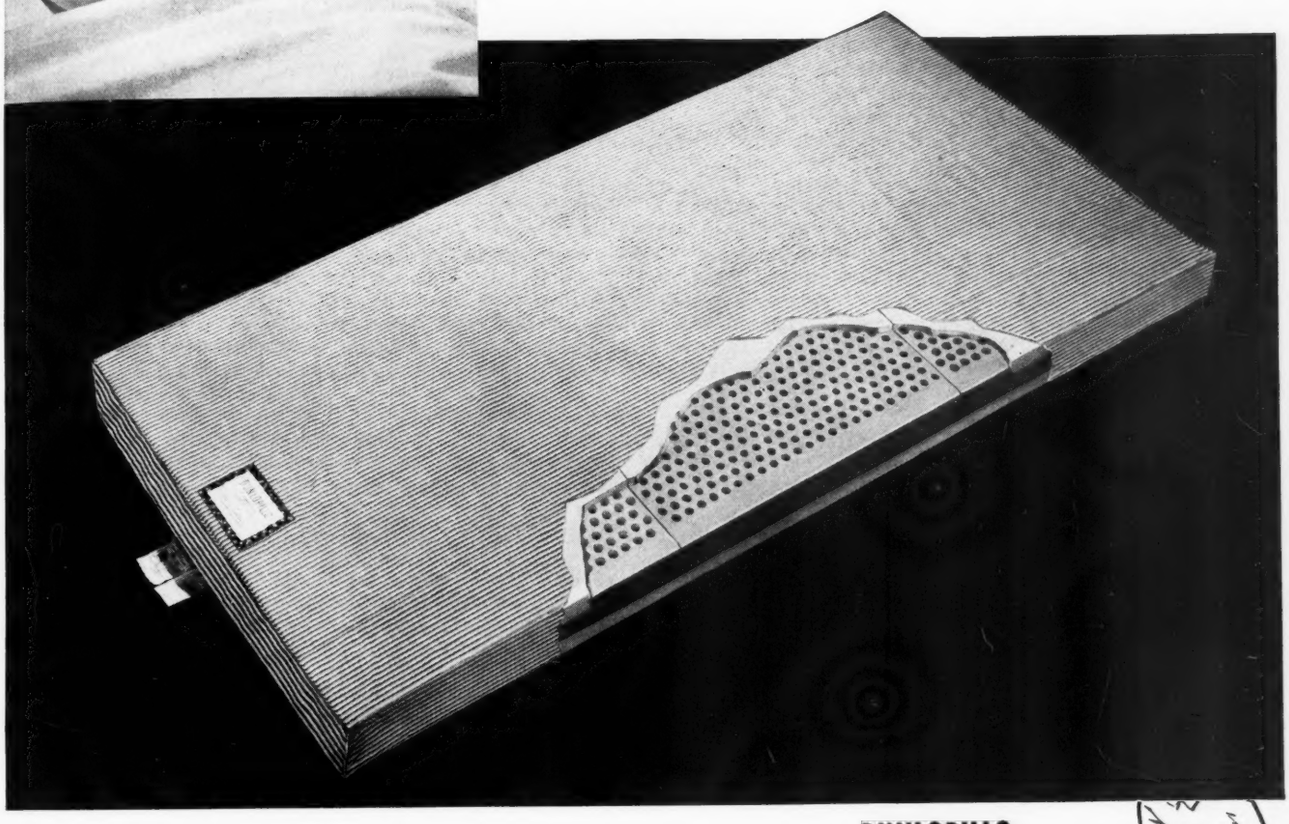
I'm Glad to be in a MODERN *Hospital*

My Hospital Bed has been as Comfortable as my own with a DUNLOPILLO MATTRESS



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From every angle—cleanliness, ease of handling, compactness for storage, comfort on any type of bed, ease of sterilization, durability — "Dunlopillo" mattresses are the answer to improved facilities. Mattresses—bed rings—knee cushions—head pillows—table pads—cast padding—miscellaneous cushions.

DUNLOPILLO BED PAD

● A new "Dunlopillo" Product! A flat bed cushion for use immediately under the patient. Fits standard pillow case. Can be laundered. Solves the pressure sore problem through aeration. Real relief for bedridden patients. Smooth, cool, comfortable. Inexpensive. Mail Coupon for further information.

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Please send me details about your new Flat Bed Cushion.

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DUNLOPILLO PRODUCTS

Trade News

Conductive Rubber Casters

• Electrically conductive casters that afford increased safety in hospital operating rooms have been marketed by the Faultless Caster Corporation, Evansville, Ind. "Condux" wheels are said to provide a safe conductor with a resistance running as low as 100 ohms per centimeter cube. In addition to the casters, the organization is also manufacturing crutch tips of the same material. These may be applied to anesthetists' stools and other stationary equipment.

Fluid Heat for Laundry Machinery

• A fluid heater and a chest type of flatwork ironer have recently been announced by the Western Laundry Machinery Company, North Kansas City, Mo. The fluid heater, which raises the temperature of a special fluid to 450° F., is used in the ironer. The high temperature increases the productive capacity of the machine approximately 25 per cent.

Story of Food Service

• A handsome brochure featuring color photographs of Edelweiss foods has recently been issued by John Sexton & Co., Chicago. Products illustrated include vegetables, relishes, fruit juice, tomato juice and a special line of foods for restricted diets.

Odors Removed

• Dorex Division of W. B. Connor Engineering Corp., New York City, has announced a new line of self-contained odor absorbers. The units consist of canisters containing especially processed, Dorex-activated coconut shell carbon, a dust filter and either a propeller or blower type of fan. The fan pulls contaminated air through the carbon and releases it free from odors at room temperature. The units are available in capacities ranging from 150 to 1500 cubic feet per minute.

Dishwasher Saves Space

• A compact new dish and glass washing unit recently marketed by Hobart Manufacturing Company, Troy, Ohio, combines a brush type of glasswasher with the wash and rinse capacity of regular dishwashing equipment. Glasses may be brushed and rinsed after each use or washed and rinsed in the dishwashing unit during rush hours and brushed once a day to remove any alkali deposits.

Bulletin for Surgical Supervisors

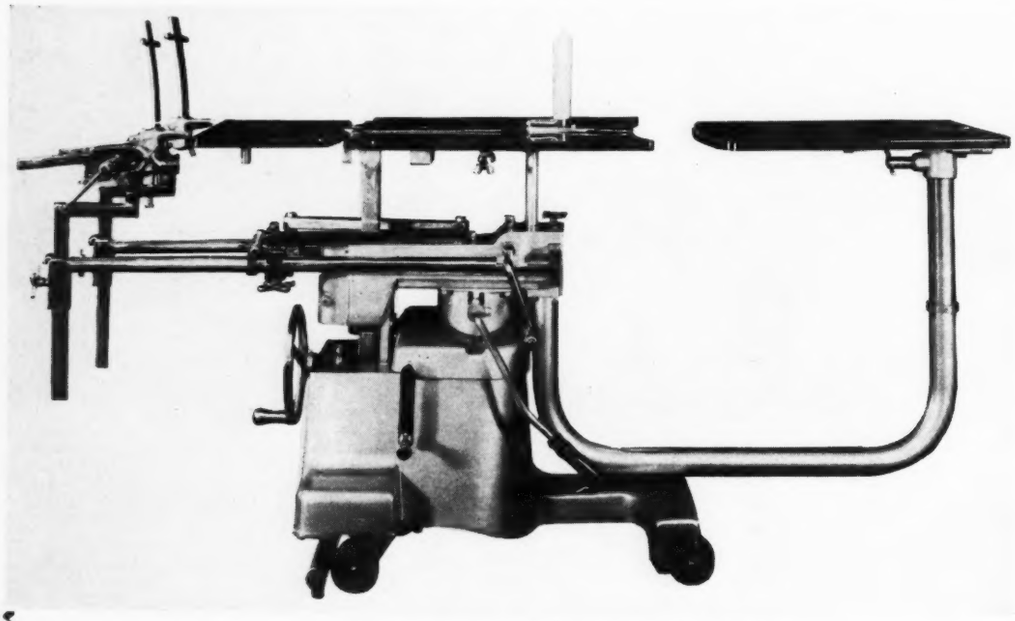
• American Sterilizer Company, Erie, Pa., released the first issue of its new bulletin, "The Surgical Supervisor," on January 1. The booklet is to be devoted to discussions of work done in the field of surgical sterilization. The first issue contains a history of sterilization and an outline of basic requirements. Future issues will deal with specific details of technic. The booklet will be published six times a year.

Notes and News

• A. C. Boylston has been named president of Mallinckrodt Chemical Works, St. Louis, to succeed the late Oscar L. Biebinger. S. W. Coleman, former merchandise manager of the organization, has been appointed general sales manager.

The election of Harry M. Berner as vice president of American Hospital Supply Corporation, Chicago, has been announced by Foster G. McGaw, president of the company. Gladys Holm was named assistant secretary.

R. H. Unseld has been appointed advertising manager of Bell & Howell Company, Chicago.



THE ALBEE-COMPER FRACTURE TABLE

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CRUTCHES—Comper Knee and Foot Rests
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COMPER MANUFACTURING COMPANY
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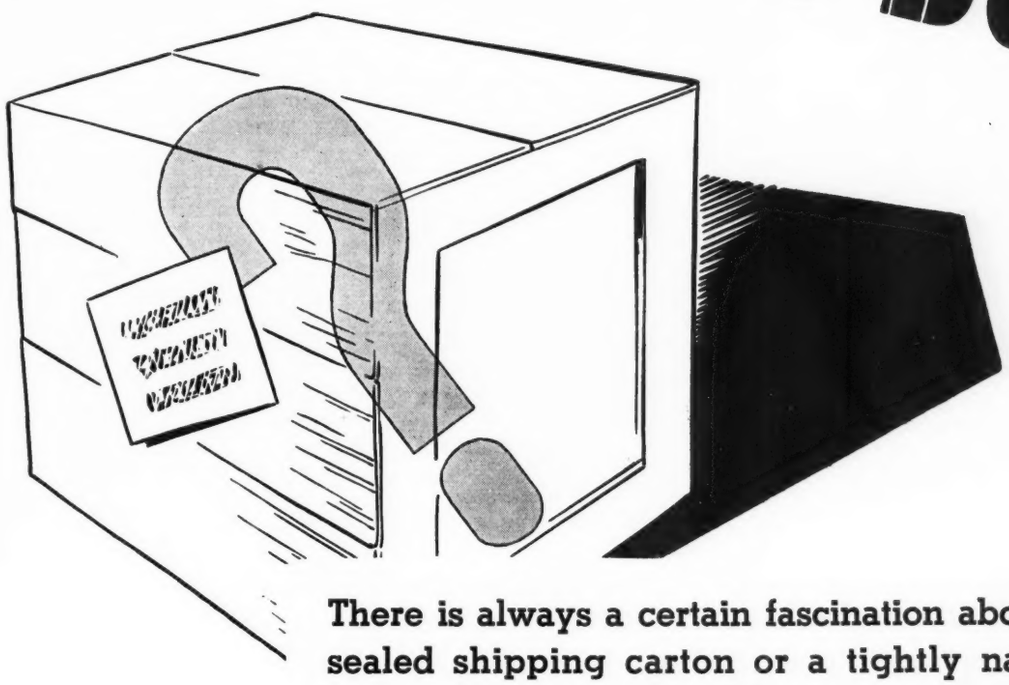
DESIGNERS AND MANUFACTURERS OF HOSPITAL EQUIPMENT

WHAT'S IN THE Box?



There is always a certain fascination about a sealed shipping carton or a tightly nailed crate. "What is it?" "Where is it going?"

If the box comes from Will Ross . . . you can just bet your last dollar that it contains *exactly what was ordered.* The contents will be just as described in the Will Ross catalog . . . invoiced at known prices, free from secret discounts, rebates, or price camouflage of any kind.

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Books on Review

MAN'S GREATEST VICTORY OVER TUBERCULOSIS. *By J. A. Myers, Ph.D., M.D. Springfield, Ill.: Charles C. Thomas.* 1940. $5.

This is the story of a great American achievement, the control of tuberculosis among cattle. With the cooperation of enlightened cattle owners and local and state governments the tuberculosis eradication division of the Bureau of Animal Industry of the U. S. Department of Agriculture, organized in 1917, accomplished its purpose by November 1940. By the use of the tuberculin test the tubercular animals were found and eliminated from the herds throughout the country. Today in every county the percentage of cattle showing a positive reaction to the tuberculin test has been reduced to less than 0.5 per cent, thus freeing the country of a great scourge.

While in 1921 it was estimated that the annual loss due to tuberculosis in cattle amounted to $30,000,000, by 1930 the tuberculosis eradication work resulted in an annual increase of $500,000,000 to the farmers of the country. Simultaneously one of the sources of human tuberculosis has been dried up, and countless human lives have been saved by being protected from an infection with a devastating disease. The control of bovine tuberculosis, accomplished in such a short time, offers the most convincing proof that our present day methods used in the combat against human tuberculosis are effective weapons in accomplishing their ultimate goal.

The story is well told by Doctor Myers, who documents his material with authoritative data, diligently gathered from all available sources. His language is simple and free from the jargon of the technical worker. This book should be read with profit by everyone interested in health work, hospital people included. —MAXIM POLLAK, M.D.

NURSING CARE OF PATIENTS WITH INFANTILE PARALYSIS. *By Jessie L. Stevenson, R. N., consultant in orthopedic nursing, National Organization for Public Health Nursing. New York: National Foundation for Infantile Paralysis,* 1940. *Free.*

This pamphlet is a welcome handbook for all nurses, particularly those in the orthopedic and public health fields. In it Miss Stevenson has outlined briefly and clearly the important aspects of the care of infantile paralysis during the acute, convalescent and chronic stages of the disease.

The line drawings showing bed positions, improvised home equipment and technics of handling patients with various combinations of paralysis are valuable to physicians and nurses in teaching the family how to protect the patient's weak muscles at all times and how to keep the patient happy and contented during the important period of convalescence after an attack of infantile paralysis.—CORALYNN A. DAVIS.

SURGERY AS A CAREER. *Published by the Institute for Research, Chicago.* 1940. *Pp.* 24. $1.

Into the 17 large pages of this brochure is packed a wealth of accurate information regarding the career of a surgeon. It should be of inestimable value to those who are considering surgery as a vocation—not only to medical and college students but even to the boy in high school. It discusses fully the requirements in education and postgraduate training, the expenses, the personal qualifications, the attractive and the unattractive features, the income possibilities and the opportunities that are open to a surgeon in the government services.—FREDERICK CHRISTOPHER, M.D.

"I want a job operating your switchboard!"
". . . and don't turn me down because I'm out of date. I bought this outfit the year your communicating and signaling system was installed."
If your signaling and communication arrangements are no longer adequate for the traffic they have to handle, the chances are that they could be modernized . . . brought right up to 1941 standards, out of maintenance budgets. For instance, are you aware of the many new efficiencies that can be created in your hospital by installing a Connectacall system to provide two-way patient and nurse communication (illustrated below).
Call in the "Connecticut" man, or drop a line to our office. Let us tell you how simple, effective, and inexpensive such modernization can be.
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Around the Clock with WYANDOTTE DETERGENT

THE proper budgeting of time is an important factor in hospital routine. There is activity all around the clock. And nowhere in the world is cleanliness so important.

Hospital superintendents everywhere find that *one* cleanser, *Wyandotte Detergent*, when used on floors, walls, tile, porcelain or painted surfaces, saves time and money and pays dividends in all-around hospital cleanliness.

WALLS: Oil-painted surfaces of all kinds are easily and economically washed with *Wyandotte Detergent* . . . no scratching, dulling, or discoloring of the washed areas.

MARBLE: Used as a poultice on marble, *Wyandotte Detergent* actually draws out stains, dirt and discoloration. Easy, inexpensive, efficient.

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Your Wyandotte Representative will be glad to demonstrate the many ways the many Wyandotte Products can cut your cleaning time and costs. Write for free booklet: *Simplified Cleaning for Hospitals.*

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Reader Opinion

Salary Surveys—"Against"

Sirs:

I believe that hospitals should help one another in every way that they can by the exchange of data. I commend many of the studies that you have conducted and published. Nevertheless, I have for some time felt that it was unwise to stress the importance of salaries and wages and to publish these from time to time in the journals. To collect this information for certain sections of the country, for their own use, as has been done here in Boston, for instance, by the hospital council, and to interchange this information among the hospitals themselves is helpful. But I believe it harmful and dangerous to publish this in periodicals where it is available for comparison by anyone who wishes to look in the magazine.

N. W. Faxon, M.D.,
Director.
Massachusetts General Hospital,
Boston.

While it is true that large hospitals in metropolitan areas have simple and easy methods of obtaining salary data, especially if they are members of hospital councils or regional associations, this is less true of the hospitals in isolated regions or of the small hospitals that do not have the stenographic and clerical assistance necessary to compile and tabulate complicated salary studies. Unless material of this kind is published in the hospital magazines, it is unlikely that the more remote hospitals will ever be given the opportunity to utilize it.

A carefully prepared salary study, representing experience in the various parts of the country and with a consistent method of handling the value of maintenance, is more reliable as a basis for decision than a mere show of hands at a hospital meeting.

There appears to be a growing feeling among hospital administrators that their institutions should pay salaries that are sufficiently high so that the hospitals need not apologize when these salaries are made known for comparison with salaries paid in industry. Of course, when maintenance is provided to hospital employes their cash salaries are proportionately smaller. The figures published in The Modern Hospital include maintenance as well as cash.

The generous and widespread response to the questionnaire would seem to indicate that many hospitals in the United States and Canada think that such a study is useful.—Ed.

Salary Surveys—"For"

Sirs:

The series of articles that you are running now on salaries of various individuals employed by hospitals is exceedingly interesting and most helpful. I trust that you will continue the series throughout the year, covering such positions as roentgenologist, pathologist, x-ray, laboratory and physical therapy technicians, chief anesthetist, historian, admitting officer, night superintendent, storekeeper and chef.

J. J. Weber,
Administrator.
Vassar Brothers Hospital,
Poughkeepsie, N. Y.

The first of the new series of salary studies on personnel appears on page 47. Other classifications will follow in the next twelve months. The data on salaries for radiologists and pathologists were so diverse in character that it was found to be impossible to tabulate them properly. —Ed.

OUR HEADWORK SAVES YOU FOOTWORK

Wall Type has attractive plastic base—the modernly styled base demanded by modern Hospitals.

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2 Combination spout swivel device and filler plug permits spout to swing from left to right. Removable to permit easy filling.

3 Horizontal Dispensing spout cuts down overall height—eliminates dripping.

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